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(Public Law 99-272; April 7, 1986)

VETERANS' HEALTH-CARE AMENDMENTS OF 1986

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

APRIL 1986

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FOREWORD

On March 18 and 20, 1986, the Senate and the House of Representatives, respectively, passed and cleared for the President's signature a major piece of legislation, the Consolidated Omnibus Budget Reconciliation Act of 1985 (H.R. 3128). Title XIX, "Veterans' Programs", of that measure makes extremely important, wide-ranging revisions in chapter 17 of title 38, United States Code, which governs the furnishing of health-care services to our Nation's veterans by the Veterans' Administration.

Because of the importance of this legislation for veterans, the scope and complexity of the many issues with which it deals, and the magnitude of the administrative challenge to the VA's Department of Medicine and Surgery that implementation of this legislation presents, the Committee's ranking minority member, Senator Alan Cranston, and I directed the Committee's majority and minority staffs, along with our printer, to compile this publication. It incorporates in one document the legislation itself and certain key materials relating to its legislative history as a timely aid to an in-depth understanding of this measure. In addition, this publication contains a so-called "Cordon rule", a document which shows the changes that the legislation makes in existing statutes. Since the time pressure in December 1985 for filing the conference report on H.R. 3128 was so great, there was not time at that point to prepare such a document to be appended to the conference report or printed in the *Congressional Record* in connection with the Senate's consideration of this legislation. However, this document has been prepared in the meantime and is included in this publication.

Senator Cranston and I believe that this publication will be a useful tool for all those who wish to have a comprehensive understanding of this legislation and its implications.

FRANK H. MURKOWSKI,
Chairman, Committee on Veterans' Affairs,
United States Senate.

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Explanatory Note

The following materials relate to title XIX of H.R. 3128, the Consolidated Omnibus Budget Reconciliation Act of 1985, as passed in its final form by the Senate and the House of Representatives on March 18 and 20, 1986, respectively. Earlier, on December 19, 1985, the Committee of Conference on H.R. 3128 submitted a conference report which the Senate passed on that same day. In the House, the conference report was rejected but the provisions of the conference report (minus certain provisions relating to the Environmental Protection Agency's Superfund and revenues therefor) were passed as an amendment to the pre-conference Senate amendment to the bill.

Thus, the Joint Explanatory Statement of the Committee of Conference and the floor statements included in this publication were made in December 1985. They pertain to and constitute legislative history of the provisions of the legislation as finally agreed to in both Houses.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

TITLE XIX—VETERANS' PROGRAMS

On October 24, 1985, the House passed H.R. 3500, the proposed "Omnibus Budget Reconciliation Act of 1985". Title X of the bill included the provisions of H.R. 1538, ordered reported by the House Committee on Veterans' Affairs on September 11, 1985, to satisfy its reconciliation instructions contained in section 2 of the First Concurrent Resolution on the Budget for Fiscal Year 1986 (S. Con. Res. 32).

On November 14, the Senate passed H.R. 3128, the proposed "Deficit Reduction Amendments of 1985", after striking out the House-passed text and inserting in lieu thereof the text of S. 1730, title XI of which contained the legislation reported by the Senate Committee on Veterans' Affairs to satisfy its reconciliation instructions in section 2 of the FY 1986 budget resolution.

On December 5, the House amended the Senate-passed H.R. 3128 by inserting the House-passed texts of H.R. 3500 and H.R. 3128, and requested a conference with the Senate. Title X of H.R. 3500 as it originally passed the House was redesignated as Title X (sections

1951-1982) of Division A of the House amendment to the Senate amendment to H.R. 3128.

The following material refers to the Senate amendment to H.R. 3128 as the "Senate bill", to the House amendment to the Senate amendment as the "House bill", and to title XIX of the Reconciliation Act conference report as the "conference agreement".

SUBTITLE A—HEALTH CARE

Both the House bill (section 1972) and the Senate bill (sections 1101-07) would, as discussed below, amend chapter 17 of title 38, United States Code, to revise existing eligibilities for health care furnished by the Veterans' Administration, and to establish a "health-care income threshold" for purposes of determinations of eligibility based on "inability to defray" the cost of needed care.

The conference agreement (section 19011) contains such provisions as discussed below.

Hospital Care

House bill

The House bill would amend the eligibility requirements, set forth in present section 610(a) of title 38, for veterans seeking VA hospital care. The six categories of veterans eligible for such health care under current law would be revised and restated as nine separate categories, and the separate basis of eligibility for non-service-connected veterans 65 years of age or older (without regard to income) contained in current law would be eliminated.

Under the House bill, the Administrator would be required to furnish hospital care determined by the Administrator to be necessary to:

(1) any veteran for a service-connected disability;

(2) a veteran discharged for a disability incurred or aggravated in line of duty;

(3) a veteran entitled to receive disability compensation;

(4) a veteran disabled as a result of VA treatment or vocational rehabilitation;

(5) certain Vietnam veterans exposed to certain toxic substances and veterans exposed to ionizing radiation from nuclear explosions;

(6) former prisoners of war;

(7) veterans of the Spanish American war, Mexican border period, or World War I; and

(8) veterans who are unable to defray the expenses of necessary care.

The current limitation on furnishing hospital care "within the limits of Veterans' Administration facilities" would no longer be applicable to these eight categories of eligible veterans.

A veteran would be eligible for necessary medical care under category (8) if the veteran's family's income in the 12 months preceding the application for care was not greater than 3.34 times the maximum annual rate of VA pension payable to totally disabled veterans (referred to below as the "health-care income threshold"). In determining the incomes of veterans for the purpose of this cate-

gory, the Administrator would be required to use the same methods and criteria used to determine annual income (including taking into account family income) for the purposes of VA improved pension eligibility under chapter 15 of title 38, United States Code. The maximum income level for health care would be increased each year by the same percentage increase applicable to the maximum pension rate. Thus, as of the time the House passed the bill, the "health care income threshold" would be $19,068 for a veteran with no dependents and $24,977 for a veteran with one dependent, plus $3,233 for each additional dependent. On December 1, 1985, the VA pension income standard increased by 3.1 percent, by virtue of present section 3112(a) of title 38, United States Code, and reference to the consumer price index.

The House bill would establish, as a ninth category of veterans eligible for hospital care, those seeking care for treatment of non-service-connected disabilities who do not fall into one of the eight other categories. Thus, this last category would consist of those veterans whose income and assets exceed the health-care income eligibility threshold. They would be required to make an annual payment equal to the Medicare deductible ($492 in 1986) in order to receive needed care. Such care could be provided only "within the limits of Veterans' Administration facilities".

The House bill would also provide that nothing in these provisions would (1) require the Administrator to furnish hospital care in a facility other than a VA facility or to furnish care to a veteran to whom another agency of a Federal, State, or local government has a duty to provide care in an institution of that government, or (2) restrict the Administrator's discretion to determine the appropriateness of furnishing medical services, therapies, or programs under chapter 17 of title 38 or in what manner they will be furnished.

Senate bill

The Senate bill would create three categories of eligibility for hospital care. Under the first category, the Administrator would be required to furnish hospital care determined to be reasonably necessary for service-connected disabilities and for any disability of veterans who have service-connected disabilities rated at 50 percent or more. This care would be required to be furnished through VA facilities or, to the extent authorized, through non-VA facilities except in the case of a veteran under incarceration as to whom the Administrator could (1) decide not to furnish care in a VA facility if to do so would not be feasible in terms of the security that would be necessary and (2) provide care under contract in a non-VA facility to the extent authorized.

Under the second category, which would remain essentially unchanged from current law (except that the separate basis of eligibility for veterans 65 years of age or older would be eliminated), the Administrator would be authorized, through VA facilities or, to the extent authorized, through non-VA facilities, to furnish reasonably necessary hospital care to veterans with service-connected disabilities rated at less than 50 percent; veterans who, but for the receipt of retired pay, would be entitled to disability compensation; veterans who are eligible for compensation for disabilities incurred

as VA patients or as participants in a VA vocational rehabilitation program; veterans who were discharged from military service for disabilities incurred or aggravated in the line of duty; former prisoners of war; Vietnam veterans exposed to certain toxic substances and veterans exposed to ionizing radiation from nuclear explosions; Spanish American War, Mexican border period, or World War I veterans; and veterans unable to defray the cost of necessary care.

Under the third category, the Administrator would have the authority, through VA facilities or, to the extent authorized, through non-VA facilities, to furnish, to the extent facilities and resources are otherwise available, reasonably necessary hospital care for the non-service-connected disability of a veteran not included in categories one or two whose annual family income for the calendar year preceding the veteran's application for care exceeds $25,000 and who agrees to make certain payments to the United States in connection with such care. In determining the incomes of veterans for the purpose of this category, the Administrator would be required to use the same methods and criteria used to determine annual income (including taking into account family income) for the purposes of VA improved pension eligibility. Further, the Administrator would be given authority to prescribe regulations defining the circumstances under which a non-service-connected veteran having an annual income or estate above a certain level would be ineligible for VA care.

Conference agreement

The conference agreement (section 19011(a)) generally follows the House provision. It would establish two groups of VA health-care eligibilities. Under the first group, the conference agreement would require the Administrator to furnish needed hospital care through VA facilities, and authorize the Administrator to furnish needed hospital care in non-VA facilities as authorized, to the first eight categories from the House bill except that the third category from the House bill is subdivided into two categories—veterans with service-connected disabilities rated at 50 percent and above and any other veterans who have service-connected disabilities. The ninth category of veterans would consist of veterans who are unable to defray the expenses of necessary care—those who are receiving chapter 15 VA improved pension or are eligible for Medicaid or whose annual family incomes do not exceed the "Category A threshold" ($15,000 for veterans with no dependents and $18,000 for veterans with one dependent with an increase of $1,000—approximately equal to the amount of the VA pension allowance ($999 as of December 1, 1985)—for each additional dependent). These amounts would be increased on January 1 of each year (beginning January 1, 1987) by the same percentage by which VA chapter 15 improved pension benefits are increased on the preceding December 1 (pursuant to section 3112 of title 38).

The conferees intend that, for the categories of veterans specified in section 610(a)(1) of title 38 (as revised by this section)—those to whom the Administrator is required to furnish hospital care—the VA's sole obligation with respect to needed hospital care for these veterans is (1) if a veteran is in immediate need of hospitalization, to furnish an appropriate bed at the VA facility where the veteran

applies or, if none is available there, to furnish a contract bed (as authorized under current law as recodified in new section 603) or to arrange to admit the veteran to the nearest VA medical center (VAMC), or Department of Defense facility with which the VA has a sharing agreement, with an available bed, or (2) if the veteran needs non-immediate hospitalization, to (A) schedule the veteran for admission where the veteran applied, if the schedule there permits, or (B) refer the veteran for scheduling and admission to the nearest VAMC, or DOD facility with which the VA has a sharing agreement, with an available bed and facilitate the veteran's admission there. The VA, of course, as also noted above, would also retain any existing discretionary authority to furnish health care to these veterans.

Also, if there are 2 or more veterans applying for the same bed at a particular facility on a non-emergent basis and one is seeking care for a service-connected disability or has a 50-percent-or-more service-connected disability, the conferees intend that that veteran should receive the bed. With respect to the remaining veteran, he or she, as noted above, would be scheduled for the next available bed at the VA facility where the veteran applies or, if none is available there, would be furnished a contract bed (as authorized under current law as recodified in new section 603) or arrangements would be made (1) to admit the veteran to the nearest VA medical center (VAMC), or Department of Defense facility with which the VA has a sharing agreement, with an available bed, or (2) if the veteran needs non-immediate hospitalization, to (A) schedule the veteran for admission where the veteran applied, if the schedule there permits, or (B) refer the veteran for scheduling and admission to the nearest VAMC, or DOD facility with which the VA has a sharing agreement, with an available bed and facilitate the veteran's admission there. The VA, of course, as also noted above, would also retain any existing authority to furnish health care to that veteran.

The conference agreement (section 19011(a)) would provide for a second eligibility group as to which the Administrator "may", through VA facilities and through non-VA facilities as authorized, furnish needed hospital care to the extent that resources and facilities are available, to non-service-connected veterans with incomes above $15,000 for those with no dependents and $18,000 for those with one dependent, plus $1,000 for each additional dependent. For those non-service-connected veterans with incomes above the "Category B" threshold ($20,000 for those with no dependents and $25,000 for those with one dependent, plus $1,000 for each additional dependent), the Administrator "may", through VA facilities and through non-VA facilities as authorized, and to the extent that resources and facilities are otherwise available, furnish needed hospital care if the veteran agrees to make certain payments to the VA in connection with that care. Each of these amounts would be increased on January 1 of each year (beginning January 1, 1987) in accordance with the VA pension-COLA increase percentage.

The conference agreement further includes a provision specifying that nothing in section 610 of title 38, relating to eligibility for hospital and nursing home care (as revised by the conference agreement), requires the VA to furnish care to a veteran to whom an-

other government entity has a legal duty to provide care in a government institution—for example, this would apply to an incarcerated veteran.

With respect to the revisions in hospital-care eligibility, the conferees intend that care be furnished to service-connected disabled veterans, low-income veterans, and, to the extent resources are available, other eligible veterans.

The conferees note with approval the statements made by the Chairman and Ranking Minority Member of the Senate Committee on Veterans' Affairs during the debate on the Senate bill (pages S15467 and S15471, respectively, of the Congressional Record for November 14) with respect to the effect of the use of the word "may" in providing VA health-care eligibility (in current law and the revised eligibility provisions) from the standpoint that the term does not connote discretion, on the part of the Administration, to withhold funds appropriated for the furnishing of care or, on the part of the VA, to withhold needed care that the VA has the capacity to provide. As indicated there, and the conferees agree, the amount of care that the VA provides to eligible veterans necessarily depends upon the level of funds appropriated for that purpose.

The conferees further note that this legislation would not change current law or practice regarding the beneficiary travel program.

The conferees recognize that in some cases it may not be readily determined with certainty, at the time that the veteran first applies for VA care during a calendar year, to which eligibility category the veteran belongs. Thus, where necessary to avoid delaying medical attention beyond the point at which it may be needed, the conferees intend that the VA make tentative eligibility-category determinations based on the available evidence at the time, subject to modification when a final determination can be made.

Also, in light of the uncertainties that may exist at the time of application and in view of the fact that even determinations based on apparently sufficient information may need to be changed on the basis of new evidence, the conferees expect the VA to require at least those veterans applying for VA care for the first time during a calendar year to sign an agreement to make the payments required by law if it is ultimately determined, by reason of their income during the preceding calendar year and any other matters relating to eligibility, that their eligibility is contingent upon their agreeing to make such payments. Of course, the agreement should also state what those payment amounts are.

In a similar vein, the conferees note that veterans with annual incomes above the applicable income threshold for payments would generally be eligible for care or services only upon the veteran (or someone authorized to act for him or her) agreeing to pay for those services before they are furnished. However, the VA has full authority under current section 611(b) to furnish hospital care or medical services in emergency cases and to charge appropriately for such care, and the conferees stress that this emergency authority would be applicable in the case of a veteran in this category of eligibility who is unable to execute such an agreement prior to the commencement of care. What, if any, payments the veteran would ultimately be required to make would, of course, depend on the eligibility determination made after the fact.

The conferees expect that the form used for the agreement to pay would clearly state eligibility criteria as well as potential liability.

Nursing Home Care

House bill

The House bill would provide that the VA "may within the limits of Veterans' Administration facilities" furnish nursing home care to the nine categories of veterans eligible for hospital care (as discussed above) under the House bill. Those veterans having incomes above the applicable "health-care income threshold" in the House bill could be furnished nursing home care if they agreed to make certain prescribed payments in connection with their care.

Senate bill

The Senate bill would provide that the Administrator, through VA facilities or through non-VA facilities as authorized, "shall" furnish nursing home care determined to be reasonably necessary for a service-connected disability and "may" furnish nursing home care determined to be reasonably necessary for any veteran having hospital care eligibility under the Senate bill (as discussed above). Those having incomes above the applicable health-care income eligibility threshold in the Senate bill could be furnished nursing home care if they agreed to make certain prescribed payments in connection with their care.

Conference agreement

The conference agreement (section 19011(a)) makes no change in VA nursing home care eligibilities in current law except to provide that non-service-connected veterans with incomes above the "Category B threshold" would be eligible only upon agreeing to make certain payments in connection with their care.

Domiciliary Care

House bill

The House bill contained no provision regarding eligibility for VA domiciliary care.

Senate bill

The Senate bill would authorize the Administrator to furnish reasonably necessary domiciliary care through VA facilities to veterans who are determined by the Administrator to be incapacitated from earning a living and to have no adequate means of support.

Conference agreement

The conference agreement makes no change in VA domiciliary-care eligibilities in current law.

In leaving current law intact regarding domiciliary-care eligibility, the conferees are not expressing their satisfaction with the status quo. Both Committees on Veterans' Affairs plan to hold hearings next year to consider appropriate revisions to the eligibility for domiciliary care as provided by section 610(b)(2) of title 38.

Outpatient Treatment and Home Health Services

House bill

The House bill would require the Administrator to furnish outpatient treatment to those veterans with outpatient treatment eligibility under current law, but would also specify that there is no requirement to furnish services to those non-service-connected disabled veterans with incomes that exceed the applicable health-care income eligibility threshold discussed above (under the heading "Hospital Care") unless they agree to make payment in connection with such services.

The House bill would make no change in eligibility for home health services except to provide that the eligibility of a non-service-connected veteran whose income exceeds the health-care income eligibility threshold would be contingent upon the veteran's agreement to make payment in connection with such services.

Senate bill

The Senate bill would amend current law to require the Administrator—"shall" rather than "may" as in current law—to furnish (directly or by contract) outpatient treatment and home health services determined to be reasonably necessary to any veteran for a service-connected disability and for any disability of a veteran with a service-connected disability rated at 50 percent or more, except in the case of a veteran under incarceration as to whom the Administrator could (1) decide not to furnish care in a VA facility if to do so would not be feasible in terms of the security that would be necessary and (2) provide care under contract in a non-VA facility to the extent authorized. Otherwise, the Senate bill would not modify current eligibilities for outpatient treatment and (except to increase the maximum amount that may be expended for home structural alterations from $600 to $2,500 for a veteran with a 50-percent-or-more-service-connected disability) home health services except to specify that non-service-connected disabled veterans with incomes above the applicable health-care income eligibility threshold would be eligible only upon agreeing to make payment in connection with such treatment or services and to the extent that resources and facilities are otherwise available.

Conference agreement

The conference agreement (section 19011(b)) would make no change in current law eligibilities relating to outpatient treatment or home health services (except with respect to the cap on home health structural alterations payments, described above) except to provide that non-service-connected veterans with incomes above the Category B threshold (discussed below under the heading "INCOME THRESHOLDS") would be eligible only upon agreeing to make payment in connection with such treatment or services and to the extent that resources and facilities are otherwise available.

Amount of Payments

Both the House and Senate bills contain provisions to specify the amounts that veterans with incomes above the income thresholds must agree to pay in order to be eligible for VA health care.

House bill

The House bill would establish payment requirements as follows:

Hospital care or nursing home care, or both: During any 12-month period, the lesser of the cost of furnishing the care or the amount of the inpatient Medicare deductible in effect at the beginning of the applicable 12-month period ($492 in 1986).

Outpatient treatment: For each visit (except for outpatient services furnished to complete treatment following hospitalization), the amount equal to 20 percent of the estimated average cost of an outpatient visit to a VA facility during the fiscal year in which the treatment is furnished.

During any 12-month period, a veteran would not be required to pay in total for any mode for care or combination of modes of care an amount greater than the amount of the inpatient Medicare deductible.

Senate bill

The Senate bill would establish payment requirements as follows:

Hospital care or nursing home care, or both: For each 60 days of care during an episode of care (a period beginning on the first day of hospital or nursing home care and ending at the close of the first period of 60 consecutive days thereafter during which the veteran receives neither hospital nor nursing home care), the lesser of the cost of furnishing the care or the amount of the inpatient Medicare deductible in effect when the care is furnished.

Outpatient treatment: For each visit, the amount equal to a percentage—the percentage that Medicare generally does not pay for such treatment (20 percent at present)—of the estimated average cost of an outpatient visit in a VA facility during the fiscal year in which the treatment is furnished.

Conference agreement

The conference agreement (section 19011(a)(2) and (b)(2)(F)) contains provisions specifying, in the cases of veterans who must agree to make payments in order to be eligible for VA health care (those with incomes above the Category B level), the amounts that they must pay, as follows:

Hospital care: During any 365-day period (1) for the first 90 days of care (or part thereof), the lesser of the cost of furnishing the care or the amount of the inpatient Medicare deductible in effect at the beginning of the 365-day period, and (2) for each succeeding 90 days of care (or part thereof), the lesser of the cost of furnishing the care or one-half of the amount of that inpatient Medicare deductible.

Nursing home care: During any 365-day period, for each 90 days of care, the lesser of the cost of furnishing the care or the amount of the inpatient Medicare deductible.

Outpatient treatment: For each outpatient or home health visit, the amount equal to 20 percent of the estimated average cost of an outpatient visit to a VA facility during the fiscal year in which the treatment is furnished, but not to exceed during any 90-day period the amount of the inpatient Medicare deductible in effect at the beginning of that period.

Combination of hospital and nursing home care: In the case of a veteran who pays the inpatient-Medicare-deductible amount in connection with VA-furnished hospital or nursing home care and who, before using 90 days of the initial mode of care (hospital or nursing home) within a 365-day period, is furnished the other mode of care, the veteran would not be required to make any payment for the second mode until either (1) the number of days of hospital and nursing home care combined exceed 90, or (2) the beginning of the next 365-day period, whichever occurs first. If the veteran pays an amount equal to one-half of the inpatient-Medicare-deductible amount in connection with receiving hospital care (as when the veteran is receiving more than 90 days of hospital care in a 365-day period) and, before using 90 days of hospital care within the applicable 365-day period, receives VA-furnished nursing home care, the veteran would be required to pay one-half of the deductible amount in connection with the number of days of nursing home care that, when added to the hospital days, do not exceed 90 within that 365-day period.

Payments for combinations of outpatient treatment and hospital and nursing home care: A veteran would not be required to pay an amount greater than the inpatient Medicare deductible in connection with any combination of outpatient and inpatient care furnished during any 90-day period.

The conferees stress that the legislation makes no change in current eligibility for contract hospital, nursing home, or outpatient care and the way that eligibility is applied and intend the Administrator to ensure that expenditures for veterans eligible for care by virtue of agreeing to make payment to the VA have the lowest priority for the use of funds available for contract care as well as the lowest priority for inpatient, outpatient, and nursing home care furnished through VA facilities.

Priorities

House bill

The House bill would repeal the provision, section 612(i) of title 38, requiring the Administrator to implement through regulations the priorities specified in that section for the furnishing of outpatient treatment.

Senate bill

The Senate bill would require the Administrator to prescribe regulations to ensure the implementation of priorities specified in the Senate bill in the furnishing of hospital, domiciliary, and nursing home care and medical services and would require the Administrator to ensure that no guideline, regulation, or other VA issuance has the effect of encouraging the furnishing of care or services in

any way inconsistent with such priorities to a veteran whose eligibility is based on agreement to make payments.

Conference agreement

The conference agreement does not contain any such provisions related to priorities except a provision (in section 19011(b)(4)) adding veterans in receipt of VA improved pension under chapter 15 of title 38, as a new, sixth priority for outpatient care under present section 612(i).

Income Thresholds

House bill

The House bill would amend section 622 of title 38, relating to evidence of veteran's "inability to defray the cost of necessary expenses" in connection with establishing eligibility for VA health care, so as to provide that (in addition to veterans in receipt of any VA pension benefits or eligible for Medicaid) a veteran shall generally be presumed to be "unable to defray" the cost of care if the veteran's family income for the 12-month period preceding the veteran's application for care was equal to or less than 3.34 times the maximum annual rate of improved pension payable to totally disabled veterans under chapter 15 of title 38 (as increased annually pursuant to section 3112 of title 38). Thus, this income threshold amount at the time the House bill was passed was $19,068 for veterans with no dependents and $24,977 for veterans with one dependent, plus $3,233 for each additional dependent. In determining a veteran's annual family income, the Administrator would consider the same items and sources of income and would allow the same exclusions as are considered and allowed under the improved pension program.

Senate bill

The Senate bill would amend section 622 to provide generally that (in addition to veterans in receipt of any VA pension benefits or eligible for Medicaid) a veteran shall be determined to be "unable to defray" the cost of care if, during the calendar year preceding the date of the veteran's application for care, the veteran's family income is not greater than $25,000 and would provide for that amount to be increased by the same percentage and at the same time as each cost-of-living adjustment is made in chapter 15 VA improved pension benefits pursuant to section 3112 of title 38. In determining a veteran's annual family income, the Administrator would be required to consider the same items and sources of income and to allow the same exclusions as are considered and allowed under the improved pension program.

The Senate bill would also provide the Administrator with discretionary authority, in order to avoid hardship, to increase the above-mentioned level for a specified geographic area.

Conference agreement

The conference agreement (section 19011(c)) would amend present section 622 to provide generally that a veteran shall be determined to be unable to defray the necessary expenses of hospital

care if the veteran receives VA improved pension or is eligible for Medicaid, or if, during the calendar year immediately preceding the veteran's application for care, the veteran's family income is not greater than $15,000 for a veteran with no dependents or $18,000 for a veteran with one dependent, plus $1,000 for each additional dependent.

A veteran would be considered not unable to defray the necessary expenses of care and thus liable for making certain payments for care (discussed above under the heading, "AMOUNT OF PAYMENTS") if the veteran's family income exceeds the Category B threshold—is greater than $20,000 for a veteran with no dependents or greater than $25,000 for a veteran with one dependent, plus $1,000 for each additional dependent. Each of the above amounts would be increased on January 1 of each year (beginning January 1, 1987) by the percentage that chapter 15 VA improved pension benefits are increased, pursuant to section 3112(a) of title 38, effective the preceding December 1.

In determining a veteran's annual income, the Administrator would be required to consider the same items and sources of income and to allow the same exclusions as are considered and allowed under the chapter 15 VA improved pension program.

Consideration of Assets in Determining Eligibility

House bill

The House bill would provide that the Administrator may refuse to determine that the veteran is unable to defray necessary medical expenses if the veteran or the veteran's immediate family has sufficient assets so that, under all the circumstances, it is reasonable that some part of those assets be consumed for the veteran's maintenance.

Senate bill

The Senate bill would provide that the Administrator shall not determine that a veteran is "unable to defray" the cost of care if the veteran or the veteran's immediate family has sufficient assets so that, under all the circumstances, the Administrator finds it unreasonable to make that determination. In determining the amount of assets, the Administrator would be required to consider the same items as the Administrator considers in determining the amount of assets for purposes of the chapter 15 improved pension program.

Conference agreement

The conference agreement (section 19011(c)) follows the House bill. In determining a veteran's assets for this purpose, the Administrator would be required to consider the same items as the Administrator considers in determining the amount of assets for purposes of the chapter 15 VA improved pension program.

Certain Adjustments of Income Eligibility Determinations

The conference agreement (revised section 622(b) of title 38) would enable the Administrator to adjust a veteran's income threshold status where necessary in order to avoid hardship to the

veteran in certain cases in which the veteran's income has dropped off substantially from the preceding calendar year amount.

Reports

Both the Senate bill (section 1108) and the House bill (section 1975) would require the Administrator of Veterans' Affairs to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives reports relating to the furnishing of health care to veterans after the enactment of this Act.

The conference agreement (section 19011(e)) would blend the Senate and House reporting requirements, with three annual reports due by February 1 of 1987, 1988, and 1989, and require the Administrator to include in the reports information regarding the numbers and characteristics of, and health care furnished to, veterans (and amounts of payments by them where appropriate) who are eligible for VA care by reason of any of the proposed new income threshold criteria, and the numbers of and health care furnished to veterans in each of the other categories of eligibility, with breakdowns, in the case of such veterans with service-connected disabilities, for each percentile disability rating.

Technical Revision of Authority to Contract for Hospital Care and Medical Services

The Senate but not the House bill (1) would delete section 601(4)(C) of title 38, which includes within the definition of "Veterans' Administration facilities"—and thus, in conjunction with provisions in sections 610 and 612, authorizes the VA to contract for hospital care or medical services with—private facilities in certain cases when VA facilities are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the care or services required, and (2) replace that provision with a new section 603, which would recodify current law under section 601(4)(C), for purposes of clarity, without making any substantive change.

The conference agreement (section 19012) follows the Senate provision.

Recovery by the United States of the Cost of Certain Health Care and Services

Both the Senate bill (section 1111) and the House bill (section 1973) would amend present section 629 of title 38, United States Code—relating to the United States' authority to recover under workers' compensation laws or plans, from automobile accident reparation (auto no-fault) insurers, and from crime-victim compensation programs the reasonable costs of VA-furnished non-service-connected health care to the extent that the insurer or program would be liable to a non-Federal provider—so as (1) to add authority for the United States to recover from a third party under a health-plan contract (a defined term that includes, for example, health-insurance policies) the reasonable costs of VA care furnished to a veteran who does not have a service-connected disability and is entitled to care or reimbursement for care from the in-

surer; (2) to require the Administrator to prescribe regulations to govern determinations of the reasonable cost of care or services; (3) expressly to authorize the Administrator to compromise, settle, or waive claims of the United States under section 629; (4) to specify that money collected under section 629 shall be deposited in the Treasury; and (5) to provide for the changes in existing law made by amendments to section 629 to apply prospectively, that is, only with respect to care furnished after the date of enactment and only with respect to health-plan contracts that are entered into, renewed, or modified after the date of enactment.

The conference agreement (section 19013) contains these provisions.

The conferees note that, in revising the wording of existing provisions of section 629 pertaining to recovery under workers' compensation laws or plans, from automobile accident reparation insurers, and from crime-victim compensation programs, the conferees do not intend to make any substantive revisions in current law or in its application or to overrule any judicial interpretations of these provisions.

The Senate bill, but not the House bill, would delete from section 629(b) provisions specifying that the amount that the United States may recover under that section may not exceed the lesser of (1) the reasonable cost of care involved as determined by the Administrator, or (2) the maximum amount specified by applicable State or local law or by any relevant contractual provision.

The conference agreement (revised section 629(a)(1) of title 38) follows the Senate provision.

The conferees agree that, in light of the provisions in section 629(a) providing for recovery by the United States of the reasonable cost of the VA-furnished care "to the extent" that the veteran (or the provider of the care) would be eligible for payment for the care had it been furnished by a non-Federal provider, the provisions being deleted are surplusage.

The Senate bill, but not the House bill, would specify, in the case of a health-plan contract containing the requirement for payment of a deductible or copayment by the veteran, (1) that the veteran's not having paid the deductible or copayment with respect to VA-furnished care does not preclude recover under section 629, (2) that the amount that the United States may recover under section 629 shall be reduced by the appropriate deductible or copayment amount, or both, and (3) that a veteran eligible for VA care shall not be required by reason of section 629 to make any copayment or deductible payments in order to receive such care.

The conference agreement (revised section 629(a)(3) contains these provisions.

The Senate bill, but not the House bill, would (1) require the Administrator, before prescribing the regulations for determining the reasonable cost of care or services (discussed above), to consult with the Comptroller General of the United States; (2) require the Comptroller General, within 45 days after the regulations (or any amendment to them) are prescribed, to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the Comptroller General's comments on and recommendations regarding such regulations (or amendments); and (3) require

that the regulations provide that in no event may such reasonable cost exceed an amount equal to what the third party would pay for the care or services under the prevailing rates applicable under its contracts with non-Federal facilities in the geographic area in which the VA facility that provided the care or services is located.

The conference agreement (revised section 629(C)(2)) follows the Senate amendment.

The House bill, but not the Senate bill, would provide the Administrator with express authority to enter into agreements with health-plan contractors for the purpose of determining reasonable costs.

The conference agreement does not contain this provision.

The conferees note that the Administrator is already authorized by section 213 of title 38, relating to the Administrator's authority to enter into contracts for necessary services, to enter into such agreements.

Both the Senate and the House bills would require that the medical records of a health-plan beneficiary for the cost of whose care recovery is sought be made available for the purpose of enabling the third party to verify that the care for which recovery is sought was furnished. The Senate bill, but not the House bill, would also provide that the records shall be made available under such conditions to protect their confidentiality as the Administrator shall prescribe in regulations and that the records may also be made available to permit the third party to verify that the provision of the care involved meets criteria generally applicable under the health-plan contract.

The conference agreement (revised section 629(h)) follows the Senate bill.

The Senate bill, but not the House bill, would require the Administrator to submit to the Committees on Veterans' Affairs a 6-month report and annual reports on the process for and results of the implementation of the amendments to section 629.

The conference agreement would require two such reports, one due not later than 6 months after the date of enactment and the other, to provide information through at least the end of fiscal year 1987, due not later than February 1, 1988.

Medicare Providers' Acceptance of Veterans' Administration Beneficiaries at Medicare Rates

The House bill (section 1974), but not the Senate bill, would amend chapter 17 of title 38, United States Code, relating to VA health care, to insert a new section 625 to require non-Federal providers of hospital services under the Medicare program to accept VA beneficiaries on a basis similar to that on which they accept Medicare beneficiaries; to require those providers to accept VA payments made in accordance with VA regulations as payment in full; to authorize the Administrator to report violations of these requirements to the Secretary of Health and Human Services; and to authorize the Secretary to terminate a provider's participation in the Medicare program on the basis of such violations.

The conference agreement does not contain this provision.

SUBTITLE B—COMPENSATION RATE INCREASES

[Deleted in final version of the legislation.]

SUBTITLE C—MISCELLANEOUS PROVISIONS

[Redesignated as "Subtitle B" in the final version of the legislation.]

Epidemiological Study of Female Vietnam Veterans

The House bill (section 1982), but not the Senate bill, would require the Administrator to provide for the conduct of an epidemiological study of any long-term adverse gender-specific health effects in female Vietnam veterans that may result from their exposure to Agent Orange or to other phenoxy herbicides and would authorize the Administrator to expand the scope of the study to evaluate any long-term adverse gender-specific health effects in females resulting from other aspects of service in Vietnam. However, the Senate, on December 2, 1985, passed a similar provision in S. 1887, the "Veterans' Compensation and Benefits Improvement Act of 1985", (section 507), that would unless determined not to be scientifically feasible, require the Administrator to provide for the conduct of a female Vietnam veterans health-experience study and permit investigation of any long-term adverse health effects which may have resulted from traumatic experiences, exposure to phenoxy herbicides (including Agent Orange), or other experience or exposure.

The conference agreement (section 19031) follows the Senate provision.

Advisory Committee on Native-American Veterans

The House bill (section 1981), but not the Senate bill, would provide for the establishment of a VA Advisory Committee on American-Indian Veterans to examine and evaluate VA programs and activities with respect to the needs of American-Indian veterans and to transmit reports on its examinations and evaluations to the Administrator of Veterans' Affairs for subsequent transmittal to the Congress. However, on December 2, 1985, the Senate passed a comparable provision in S. 1887, the "Veterans' Compensation and Benefits Improvements Act of 1985" (section 505), which would provide for the establishment of a VA Advisory Committee on Native-American Veterans (including Alaska Natives).

The conference agreement (section 19032) contains such a provision, blending together aspects of the two provisions, naming the Advisory Committee the "Advisory Committee on Native-American Veterans" and specifying that representatives of American Indians and of other Native Americans each would serve on the Committee.

Waiver of Waiting Period for Administrative Reorganization of Certain Veterans' Administration Automated Data Processing Activities

The conference agreement (section 19033) also contains a provision that would waive the waiting period prescribed by section

210(b)(2) of title 38—which provides, in part, that the VA may not in any fiscal year implement certain administrative reorganizations unless the Administrator, not later than the date on which the President submits the budget for that year, submits a report containing a detailed plan and justification for the reorganization—with respect to a reorganization, described in letters dated November 1, 1985, that were submitted to the chairman and ranking minority members of the Committees, involving the transfer of certain functions from the VA's Office of Data Management and Telecommunications to the VA's Department of Veterans' Benefits and requesting a waiver of that waiting period.

The conferees have determined that the information contained in the November 1 letters, together with other information subsequently provided to the Committees, constitutes a sufficiently detailed plan and justification (as that term is proposed to be defined by section 501 of S. 1887, as passed by the Senate on December 2, 1985) for this proposed reorganization and that the reorganization will serve to improve the operations of the VA's service and benefits delivery system. Since, under the provisions of section 210(b)(2), the reorganization would not be permitted to be implemented prior to the beginning of fiscal year 1987, the conference agreement would waive the required waiting period in order to permit the Administrator to implement this reorganization prior to October 1, 1986.

In agreeing that this statutory waiver be granted, the conferees intend that the Administrator, as part of implementing the reorganization, develop and implement plans for better coordination and integration between the Department of Medicine and Surgery and the Department of Veterans' Benefits in automated data processing modernization, and are not necessarily expressing agreement with the recommendations of the October 25, 1985, report of McManis Associates. The conferees believe that the Administrator should proceed cautiously in adopting recommendations from that report (particularly those relating to procurement). In that regard, the conferees recommend that the Administrator take full cognizance of the review being conducted by the General Accounting Office, pursuant to a request from the Chairman of the House Veterans' Affairs Committee and the Ranking Minority Member of the Senate Veterans' Affairs Committee, pertaining to certain aspects of the report.

RATIFICATION OF CERTAIN TEMPORARILY EXPIRED AUTHORITIES

Veterans' Administration Regional Office in the Philippines

The compromise agreement (section 19034(a)) contains a provision ratifying any action taken by the Administrator during the period beginning on November 1, 1985, and ending on December 3, 1985, in connection with the exercise of the Administrator's authority under section 230(b) of title 38, relating to the establishment of a regional office in the Republic of the Philippines. This authority to operate such an office expired on October 31, 1985, but was extended for three additional years by section 402 of Public Law 99–166.

Contract Care Authority in Puerto Rico and the Virgin Islands

The compromise agreement (section 19034(b)) also contains a provision ratifying any action taken by the Administrator of Veterans' Affairs in connection with entering into any contract to provide, during the period beginning on November 1, 1985, and ending on December 3, 1985, care described in subclause (v) of section 601(4)(C) of title 38, United States Code, relating to the Administrator's authority to provide hospital care and medical services in certain noncontiguous "States" (defined in present section 101(20) to include United States Territories and possessions and the Commonwealth of Puerto Rico), including any waiver made by the Administrator of the applicability to the Commonwealth of Puerto Rico or the Virgin Islands of the restrictions described in that subclause for that period. This authority to provide such care and services also expired on October 31, 1985, but was made permanent in the case of the Virgin Islands, and was extended (with certain limitations) for an additional three years in the case of Puerto Rico, by section 102 of Public Law 99-166, enacted on December 3, 1985.

ALCOHOL AND DRUG TREATMENT AND REHABILITATION CONTRACT PROGRAM

The compromise agreement (section 19034(c)) also contains a provision ratifying any action taken by the Administrator of Veterans' Affairs in connection with entering into any contract to provide, during the period beginning November 1, 1985, and ending December 3, 1985, care described in section 620A of title 38, relating to contracts for certain care and treatment and rehabilitative services for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. This authority to provide such care and services also expired on October 31, 1985, but was extended for an additional three years by section 101 of Public Law 99-166.

TEXT OF TITLE XIX, "VETERANS' PROGRAMS", OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

SEC. 19001. SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE.

(a) SHORT TITLE.—This title may be cited as the "Veterans' Health-Care Amendments of 1986".

(b) REFERENCES.—Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

Subtitle A—Health Care

SEC. 19011. ELIGIBILITY FOR HEALTH CARE OF VETERANS WITH NON-SERVICE-CONNECTED DISABILITIES.

(a) HOSPITAL CARE AND NURSING HOME CARE.—(1) Subsection (a) of section 610 is amended to read as follows:

"(a)(1) The Administrator shall furnish hospital care, and may furnish nursing home care, which the Administrator determines is needed—

"(A) to any veteran for a service-connected disability;

"(B) to a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty, for any disability;

"(C) to a veteran who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section, for any disability;

"(D) to a veteran who has a service-connected disability rated at 50 percent or more, for any disability;

"(E) to any other veteran who has a service-connected disability, for any disability;

"(F) to a veteran who is a former prisoner of war, for any disability;

"(G) to a veteran exposed to a toxic substance or radiation, as provided in subsection (e) of this section;

"(H) to a veteran of the Spanish-American War, the Mexican border period, or World War I, for any disability; and

"(I) to a veteran for a non-service-connected disability, if the veteran is unable to defray the expenses of necessary care as determined under section 622(a)(1) of this title.

"(2)(A) To the extent that resources and facilities are available, the Administrator may furnish hospital care and nursing home

care which the Administrator determines is needed to a veteran for a non-service-connected disability if the veteran has an income level described in section 622(a)(2) of this title.

"(B) In the case of a veteran who is not described in paragraph (1) of this subsection or in subparagraph (A) of this paragraph, the Administrator may furnish hospital care and nursing home care which the Administrator determines is needed to the veteran for a non-service-connected disability—

"(i) to the extent that resources and facilities are otherwise available; and

"(ii) subject to the provisions of subsection (f) of this section.

"(3) In addition to furnishing hospital care and nursing home care described in paragraphs (1) and (2) of this subsection through Veterans' Administration facilities, the Administrator may furnish such hospital care in accordance with section 603 of this title and may furnish such nursing home care as authorized under section 620 of this title.".

(2) Such section is further amended by adding at the end the following new subsections:

"(f)(1) The Administrator may not furnish hospital care or nursing home care under this section to a veteran who is eligible for such care by reason of subsection (a)(2)(B) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) of this subsection.

"(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to the lesser of—

"(A) the cost of furnishing such care, as determined by the Administrator; and

"(B) the amount determined under paragraph (3) of this subsection.

"(3)(A) In the case of hospital care furnished during any 365-day period, the amount referred to in paragraph (2)(B) of this subsection is—

"(i) the amount of the inpatient Medicare deductible, plus

"(ii) one-half of such amount for each 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period.

"(B) In the case of nursing home care furnished during any 365-day period, the amount referred to in paragraph (2)(B) of this subsection is the amount of the inpatient Medicare deductible for each 90 days of such care (or fraction thereof) during such 365-day period.

"(C)(i) Except as provided in clause (ii) of this subparagraph, in the case of a veteran who is admitted for nursing home care under this section after being furnished, during the preceding 365-day period, hospital care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of hospital care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such nursing home care until—

"(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

"(II) the end of the 365-day period applicable to the hospital care for which payment was made,

whichever occurs first.

"(ii) In the case of a veteran who is admitted for nursing home care under this section after being furnished, during any 365-day period, hospital care for which the veteran has paid an amount under subparagraph (A)(ii) of this paragraph and who has not been furnished 90 days of hospital care in connection with such payment, the amount of the liability of the veteran under paragraph (2) of this subsection with respect to the number of days of such nursing home care which, when added to the number of days of such hospital care, is 90 or less, is the difference between the inpatient Medicare deductible and the amount paid under such subparagraph until—

"(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

"(II) the end of the 365-day period applicable to the hospital care for which payment was made,

whichever occurs first.

"(D) In the case of a veteran who is admitted for hospital care under this section after having been furnished, during the preceding 365-day period, nursing home care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of nursing home care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such hospital care until—

"(i) the veteran has been furnished, beginning with the first day of such nursing home care furnished in connection with such payment, a total of 90 days of nursing home care and hospital care; or

"(ii) the end of the 365-day period applicable to the nursing home care for which payment was made,

whichever occurs first.

"(E) A veteran may not be required to make a payment under this subsection for hospital care or nursing home care furnished under this section during any 90-day period in which the veteran is furnished medical services under section 612(f) of this title to the extent that such payment would cause the total amount paid by the veteran under this subsection for hospital care and nursing home care furnished during that period and under section 612(f)(4) of this title for medical services furnished during that period to exceed the amount of the inpatient Medicare deductible in effect on the first day of such period.

"(4) Amounts collected or received on behalf of the United States under this subsection shall be deposited in the Treasury as miscellaneous receipts.

"(5) For the purposes of this subsection, the term 'inpatient Medicare deductible' means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) on the first day of the 365-day period applicable under paragraph (3) of this subsection.

"(g) Nothing in this section requires the Administrator to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government.".

(b) MEDICAL SERVICES FURNISHED ON AN OUTPATIENT OR AMBULATORY BASIS.—(1) Subsection (a) of section 612 is amended—

(A) By striking out the first sentence and inserting in lieu thereof the following:

"(1) Except as provided in subsection (b) of this section, the Administrator may furnish such medical services as the Administrator determines are needed—

"(A) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service); and

"(B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more.";

(B) by designating the sentence beginning "The Administrator may also" as paragraph (2) and in such sentence striking out "The Administrator may also furnish to any such veteran" and inserting in lieu thereof "As part of medical services furnished to a veteran under paragraph (1) of this subsection, the Administrator may furnish to the veteran";

(C) by striking out the sentence beginning "In the case of"; and

(D) by adding at the end of such subsection the following:

"(3) In addition to furnishing medical services under this subsection through Veterans' Administration facilities, the Administrator may furnish such services in accordance with section 603 of this title.".

(2) Subsection (f) of such section is amended—

(A) by striking out "The Administrator, within the limits of Veterans' Administration facilities, may" and inserting in lieu thereof "(1) Except as provided in paragraph (4) of this subsection, the Administrator may";

(B) by redesignating clause (1) as clause (A), redesignating subclauses (A) and (B) of such clause as subclauses (i) and (ii), respectively, and inserting "and" at the end of such clause;

(C) by striking out clause (2);

(D) by redesignating clause (3) as clause (B);

(E) by designating the second sentence as paragraph (2) and in such sentence striking out "The Administrator may also furnish to any such veteran" and inserting in lieu thereof "As part of medical services furnished to a veteran under paragraph (1) of this subsection, the Administrator may furnish to the veteran";

(F) by striking out the third sentence; and

(G) by adding at the end the following:

"(3) In addition to furnishing medical services under this subsection through Veterans' Administration facilities, the Administrator may furnish such services in accordance with section 603 of this title.

"(4)(A) The Administrator may not furnish medical services under this subsection (including home health services under paragraph (2) of this subsection) to a veteran who is eligible for hospital care under this chapter by reason of section 610(a)(2)(B) of this title unless the veteran agrees to pay to the United States the amount determined under subparagraph (B) of this paragraph.

"(B) A veteran who is furnished medical services under this subsection and who is required under subparagraph (A) of this paragraph to agree to pay an amount to the United States in order to be furnished such services shall be liable to the United States, in the case of each visit in which such services are furnished to the veteran, for an amount equal to 20 percent of the estimated average cost (during the calendar year in which the services are furnished) of an outpatient visit in a Veterans' Administration facility. Such estimated average cost shall be determined by the Administrator.

"(C) A veteran may not be required to make a payment under this paragraph for services furnished under this subsection during any 90-day period to the extent that such payment would cause the total amount paid by the veteran under this paragraph for medical services furnished during that period and under section 610(f) of this title for hospital and nursing home care furnished during that period to exceed the amount of the inpatient Medicare deductible in effect on the first day of such 90-day period.

"(D) This subsection does not apply with respect to home health services under this subsection to the extent that such services are for improvements and structural alterations.

"(E) For the purposes of this paragraph, the term 'inpatient Medicare deductible' means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)).

"(F) Amounts collected or received by the Veterans' Administration under this paragraph shall be deposited in the Treasury as miscellaneous receipts.".

(3) Subsection (g) of such section is amended to read as follows:

"(g)(1) The Administrator may furnish medical services which the Administrator determines are needed to a veteran—

"(A) who is a veteran of the Mexican border period or of World War I; or

"(B) who is in receipt of increased pension or additional compensation or allowances based on the need of regular aid and attendance or by reason of being permanantly housebound (or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance).

"(2) As part of medical services furnished to a veteran under paragraph (1) of this subsection, the Administrator may furnish to the veteran home health services under the terms and conditions set forth in subsection (f) of this section.

"(3) In addition to furnishing medical services under this subsection through Veterans' Administration facilities, the Administrator

may furnish such services in accordance with section 603 of this title.".

(4) Subsection (i) of such section is amended by adding at the end the following:

"(6) To any veteran who is in receipt of pension under section 521 of this title.".

(c) INCOME THRESHOLDS FOR CERTAIN NON-SERVICE-CONNECTED CARE.—(1) Section 622 is amended to read as follows:

"§ 622. Determination of inability to defray necessary expenses; income thresholds

"(a)(1) For the purposes of section 610(a)(1)(I) of this title, a veteran shall be considered to be unable to defray the expenses of necessary care if—

"(A) the veteran is eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

"(B) the veteran is in receipt of pension under section 521 of this title; or

"(C) the veteran's attributable income is not greater than the Category A threshold.

"(2) For the purposes of section 610(a)(2)(A) of this title, a veteran's income level is described in this paragraph if the veteran's attributable income is not greater than the Category B threshold.

"(b) For the purposes of this section:

"(1) The Category A threshold—

"(A) for the calendar year beginning on January 1, 1986, is—

"(i) $15,000 in the case of a veteran with no dependents; and

"(ii) $18,000 in the case of a veteran with one dependent, plus $1,000 for each additional dependent; and

"(B) for a calendar year beginning after December 31, 1986, is the amount in effect for purposes of this paragraph for the preceding calendar year as adjusted under subsection (c) of this subsection.

"(2) The Category B threshold—

"(A) for the calendar year beginning on January 1, 1986, is—

"(i) $20,000 in the case of a veteran with no dependents; and

"(ii) $25,000 in the case of a veteran with one dependent, plus $1,000 for each additional dependent; and

"(B) for a calendar year beginning after December 31, 1986, is the amount in effect for purposes of this paragraph for the preceding calendar year as adjusted under subsection (c) of this subsection.

"(c) Effective on January 1 of each year, the amounts in effect under paragraphs (1) and (2) of subsection (b) of this section shall be increased by the percentage by which the maximum rates of pension were increased under section 3112(a) of this title during the preceding calendar year.

"(d)(1) Notwithstanding the attributable income of a veteran, the Administrator may refuse to make a determination described in paragraph (2) of this subsection if the corpus of the estate of the veteran is such that under all the circumstances it is reasonable that some part of the corpus of the estate of the veteran be consumed for the veteran's maintenance.

"(2) A determination described in this paragraph is a determination—

"(A) that for the purposes of subsection (a)(1)(C) of this section a veteran's attributable income is not greater than the Category A threshold; or

"(B) that for the purposes of subsection (a)(2) of this section a veteran's attributable income is not greater than the Category B threshold.

"(3) For the purposes of paragraph (1) of this subsection, the corpus of the estate of a veteran shall be determined in the same manner as the manner in which determinations are made of the corpus of the estates of persons under section 522 of this title.

"(e)(1) In order to avoid a hardship to a veteran described in paragraph (2) of this subsection, the Administrator may deem the veteran to have an attributable income during the previous year not greater than the Category A threshold or the Category B threshold, as appropriate.

"(2)(A) A veteran is described in this paragraph for the purposes of subsection (a)(1) of this section if—

"(i) the veteran has an attributable income greater than the Category A threshold; and

"(ii) the current projections of such veteran's income for the current year are that the veteran's income for such year will be substantially below such threshold.

"(B) a veteran is described in this paragraph for the purposes of subsection (a)(2) of this section if—

"(i) the veteran has an attributable income greater than the Category B threshold; and

"(ii) the current projections of such veteran's income for the current year are that the veteran's income for such year will be substantially below such threshold.

"(f) For purposes of this section:

"(1) The term 'attributable income' means the income of a veteran for the previous year determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such veteran under section 521 of this title would be reduced if such veteran were eligible for pension under that section.

"(2) The term 'corpus of the estate of the veteran' includes the corpus of the estates of the veteran's spouse and dependent children, if any.

"(3) The term 'previous year' means the calendar year preceding the year in which the veteran applies for care or services under section 610(a) or 612(f) of this title.

"(g) For the purposes of sections 610(b)(2) and 624(c) of this title, the fact that a veteran is—

"(1) eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

"(2) a veteran with a service-connected disability; or

"(3) in receipt of pension under any law administered by the Veterans' Administration,

shall be accepted as sufficient evidence of such veteran's inability to defray necessary expenses.".

(2) The item relating to such section in the table of sections at the beginning of chapter 17 is amended to read as follows:

"622. Determination of inability to defray necessary expenses; income thresholds.".

(3) The first increase under subsection (c) of section 622 of title 38, United States Code, as added by paragraph (1), shall take effect on January 1, 1987.

(d) CONFORMING AMENDMENTS.—(1) Section 525(a) is amended by striking out "section 612(i)(5) of this title" and inserting in lieu thereof "clauses (5) and (6) of section 612(i)".

(2) Section 601(6) is amended—

(A) in clause (A)(i), by striking out "section 612(f)(1)(A)" and inserting in lieu thereof "section 612(f)(1)(A)(i)", and

(B) in clause (B)(ii), by striking out "section 612(f)(1)(B)" and inserting in lieu thereof "section 612(f)(1)(A)(ii)".

(3) Section 610(e) is amended—

(A) by striking out "may be furnished hospital care or nursing home care under subsection (a)(5)" in subparagraphs (A) and (B) of paragraph (1) and inserting in lieu thereof "is eligible for hospital care and nursing home care under subsection (a)(1)(G)"; and

(B) by striking out "subsection (a)(5)" in paragraphs (2) and (3) and inserting in lieu thereof "subsection (a)(1)(G)".

(4) Section 612A is amended—

(A) by striking out "clause (1)(B)" in subsection (b)(1) and inserting in lieu thereof "paragraph (1)(A)(ii)"; and

(B) by striking out "612(f)(2)" in subsection (e)(1) and inserting in lieu thereof "612(a)(1)(B)".

(5) Section 620(f)(1)(A)(ii) is amended by striking out "612(f)(2)" and inserting in lieu thereof "612(a)(1)(B)".

(6) Section 663(a)(1) is amended by striking out "612(f)(2)" both places it appears and inserting in lieu thereof "612(a)(1)(B)".

(e) REPORTS ON FURNISHING OF HEALTH CARE AND IMPLEMENTATION OF CHANGES IN ELIGIBILITY.—(1) The Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report for each of fiscal years 1986, 1987, and 1988 concerning the implementation of the amendments made by this section.

(2) Each report under paragraph (1) shall provide detailed information with respect to the fiscal year for which it is submitted regarding—

(A) the number of veterans who received health care from the Veterans' Administration during the fiscal year concerned (shown in total and separately for hospital care, nursing home care, outpatient care, and domiciliary care);

(B) with respect to veterans who applied for health care from the Veterans' Administration during such fiscal year but did not receive such care—

(i) the number such veterans (shown in total and separately for hospital care, nursing home care, outpatient care, and domiciliary care); and

(ii) the primary reasons why such care was not furnished;

(C) the guidelines and processes for—

(i) implementation of the income-threshold criteria for Veterans' Administration health-care eligibility established by paragraph (1) (I) and subparagraphs (A) and (B) of paragraph (2) of section 610(a) of title 38, United States Code (as added by subsection (a)), paragraph (4) of section 612(f) of such title (as added by subsection (b)), and section 622 of such title (as amended by subsection (c)); and

(ii) the collection of payments required by section 610(f) of such title (as added by subsection (a) (2)) and by section 612(f) (4) of such title (as added by subsection (b) (2));

(D) the numbers and characteristics of, and the type and extent of health care furnished by the Veterans' Administration to, veterans eligible for such care by reason of any such authorities, including—

(i) with respect to those eligible by reason of each such authority, the numbers who applied for and were furnished such care, the type and extent of such care that they were furnished, and their incomes and family sizes; and

(ii) with respect to veterans eligible by reason of section 610(a) (2) (B) of such title, the average and total payments made by such veterans for such care (shown in total and separately for hospital care, nursing home care, and outpatient care); and

(E) the numbers of, and the type and extent of health care furnished by the Veterans' Administration to, veterans eligible for such care by reason of each clause of section 610(a) (1) of such title (shown in total and separately for veterans with service-connected disabilities for each percentile disability rating).

The report for fiscal year 1986 shall include information relating only to care furnished on or after July 1, 1986.

(3) Each report under this subsection shall be submitted not later than the February 1 following the end of the fiscal year for which it is required.

(f) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section shall apply to hospital care, nursing home care, and medical services furnished on or after July 1, 1986.

(2)(A) The provisions of sections 610 and 622 of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, shall apply with respect to hospital and nursing home care furnished on or after July 1, 1986, to veterans furnished such care or services on June 30, 1986, but only to the extent that such care is furnished with respect to the same episode of care for

which it was furnished on June 30, 1986, as determined by the Administrator pursuant to regulations which the Administrator shall prescribe.

(B) During the months of July and August 1986, the Administrator may, in order to continue a course of treatment begun before July 1, 1986, furnish medical services to a veteran on an ambulatory or outpatient basis without regard to the amendments made by this section.

(C) For the purposes of this paragraph, the term "episode of care" means a period of consecutive days—

(i) beginning with the first day on which a veteran is furnished hospital or nursing home care; and

(ii) ending on the day of the veteran's discharge from the hospital or nursing home facility, as the case may be.

SEC. 19012. TECHNICAL REVISION OF AUTHORITY TO CONTRACT FOR HOSPITAL CARE AND MEDICAL SERVICES.

(a) REPEAL OF CONTRACT AUTHORITY FROM DEFINITION OF VETERANS' ADMINISTRATION FACILITIES.—Section 601 is amended—

(1) in paragraph (4)—

(A) by inserting "and" at the end of clause (A); and

(B) by striking out the semicolon at the end of clause (B) and all that follows through the end of such paragraph and inserting in lieu thereof a period; and

(2) by adding at the end the following new paragraph:

"(9) The term 'non-Veterans' Administration facilities' means facilities other than Veterans' Administration facilities.".

(b) REENACTMENT OF CONTRACT AUTHORITY.—(1) Chapter 17 is amended by inserting after section 602 the following new section:

"§ 603. Contracts for hospital care and medical services in non-Veterans' Administration facilities

"(a) When Veterans' Administration facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Administrator, as authorized in section 610 or 612 of this title, may contract with non-Veterans' Administration facilities in order to furnish—

"(1) hospital care or medical services to a veteran for the treatment of—

"(A) a service-connected disability; or

"(B) a disability for which a veteran was discharged or released from the active military, naval, or air service;

"(2) medical services for the treatment of any disability of—

"(A) a veteran described in section 612(a)(1)(B) of this title;

"(B) a veteran described in section 612(f)(1)(A)(ii) of this title; or

"(C) a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veter-

an precludes appropriate treatment in Veterans' Administration facilities;

"(3) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a Veterans' Administration facility until such time following the furnishing of care in the non-Veterans' Administraton facility as the veteran can be safely transferred to a Veterans' Administration facility;

"(4) hospital care for women veterans;

"(5) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the contiguous States, except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and non-Veterans' Administration facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the furnishing of medical services for veterans hospitalized or treated by the Veterans' Administration within the 48 contiguous States, but the authority of the Administrator under this paragraph with respect to the Commonwealth of Puerto Rico shall expire on September 30, 1988, and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the Commonwealth of Puerto Rico of the restrictions in this paragraph with respect to hospital patient loads and the incidence of the furnishing of medical services;

"(6) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent Veterans' Administration out-patient clinics to obviate the need for hospital admission; or

"(7) outpatient dental services and treatment, and related dental appliances, for a veteran described in section 612(b)(1)(G) of this title.

"(b) In the case of any veteran for whom the Administrator contracts to furnish car or services in a non-Veterans' Administration facility pursuant to a provision of subsection (a) of this section, the Administrator shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 602 the following new item:

"603. Contracts for hospital care and medical services in non-Veterans' Administration facilities.".

(c) CONFORMING AMENDMENTS.—(1) Section 612(b)(3) is amended by striking out "clause (i), (ii), or (v) of section 601(4)(C)" and inserting in lieu thereof "clause (1), (2), or (5) of section 603(a)".

(2) Section 612(b)(4) is amended by striking out "section 601(4)(C)" both places it appears and inserting in lieu thereof "section 603".

(3) Section 612A(e)(1) is amended by striking out "601(4)(C)(ii)" and inserting in lieu thereof "603(a)(2)".

(4) Section 903(a) is amended by inserting "hospital care in accordance with section 603 of this title or" after "was receiving".

(5) Section 102(b) of the Veterans' Administration Health-Care Amendments of 1985 (Public Law 99-166) is amended—

(A) by striking out "such section" in paragraph (1) and inserting in lieu thereof "section 603(a)(5)"; and

(B) by striking out "clause (v) of section 601(4)(C)" in paragraph (5) and inserting in lieu thereof "section 603(a)(5)".

SEC. 19013. RECOVERY OF THE COST OF CERTAIN HEALTH CARE AND SERVICES FURNISHED BY THE VETERANS' ADMINISTRATION.

(a) IN GENERAL.—Section 629 is amended to read as follows:

"§ 629. Recovery by the United States of the cost of certain care and services

"(a)(1) Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Administrator) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

"(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

"(A) that is incurred incident to the veteran's employment and that is covered under a workers' compenation law or plan that provides for payment for the cost of health care and services provided to the veteran by reason of the disability;

"(B) that is incurred as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance;

"(C) that is incurred as the result of a crime of personal violence that occurred in a State, or a politicial subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime; or

"(D) that is incurred by a veteran—

"(i) who does not have service-connected disability; and

"(ii) who is entitled to care (or payment of the expenses of care) under a health-plan contract.

"(3) In the case of a health-plan contract that contains a requirement for payment of deductible or copayment by the veteran—

"(A) the veteran's not having paid such deductible or copayment with respect to care or services furnished under this chapter shall not preclude recovery or collection under this section; and

"(B) the amount that the United States may collect or recover under this section shall be reduced by the appropriate deductible or copayment amount, or both.

"(b)(1) As to the right provided in subsection (a) of this section, the United States shall be subrogated to any right or claim the veteran (or the veteran's personal representative, successor, dependents, or survivors) may have against a third party.

"(2)(A) In order to enforce any right or claim to which the United States is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran (or the veteran's personal representative, successor, dependents, or survivors) against a third party.

"(B) The United States may institute and prosecute legal proceedings against the third party if—

"(i) an action or proceeding described in subparagraph (A) of this paragraph is not begun within 180 days after the first day on which care or services for which recovery is sought are furnished to the veteran by the Administrator under this chapter;

"(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute such legal proceedings; and

"(iii) a period of 60 days has passed following the mailing of such notice.

"(c)(1) The Administrator may compromise, settle, or waive any claim which the United States has under this section.

"(2)(A) The Administrator, after consultation with the Comptroller General of the United States, shall prescribe regulations for the purpose of determining the reasonable cost of care or services under subsection (a)(1) of this section. Any determination of such cost shall be made in accordance with such regulations.

"(B) Such regulations shall provide that the reasonable cost of care or services sought to be recovered or collected from a third-party liable under a health-plan contract may not exceed the amount that such third party demonstrates to the satisfaction of the Administrator it would pay for the care or services in accordance with the prevailing rates at which the third party makes payments under comparable health-plan contracts with facilities (other than facilities of departments or agencies of the United States) in the same geographic area.

"(C) Not later than 45 days after the date on which the Administrator prescribes such regulations (or any amendment to such regulations), the Comptroller General shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the Comptroller General's comments on and recommendations regarding such regulations (or amendment).

"(d) Any contract or agreement into which the Administrator enters with a person under section 3718 of title 31 for collection services to recover indebtedness owed the United States under this section shall provide, with respect to such services, that such person is subject to sections 3301 and 4132 of this title.

"(e) A veteran eligible for care or services under this chapter—

"(1) may not be denied such care or services by reason of this section; and

"(2) may not be required by reason of this section to make any copayment or deductible payment in order to receive such care.

"(f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 611(b) of this title.

"(g) Amounts collected or recovered on behalf of the United States under this section shall be deposited into the Treasury as miscellaneous receipts.

"(h)(1) Subject to paragraph (3) of this subsection, the Administrator shall make available medical records of a veteran described in paragraph (2) of this subsection for inspection and review by representatives of the third party concerned for the sole purposes of permitting the third party to verify—

"(A) that the care or services for which recovery or collection is sought were furnished to the veteran; and

"(B) that the provision of such care or services to the veteran meets criteria generally applicable under the health-plan contract involved.

"(2) A veteran described in this paragraph is a veteran who is a beneficiary of a health-plan contract under which recovery or collection is sought under this section from the third party concerned for the cost of the care or services furnished to the veteran.

"(3) Records shall be made available under this subsection under such conditions to protect the confidentiality of such records as the Administrator shall prescribe in regulations.

"(i) For purposes of this section—

"(1)(A) The term 'health-plan contract' means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.

"(B) Such term does not include—

"(i) an insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j);

"(ii) a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.);

"(iii) a workers' compensation law or plan described in subparagraph (A) of subsection (a)(2) of this section; or

"(iv) a program, plan, or policy under a law described in subparagraph (B) or (C) of such subsection.

"(2) The term 'payment' includes reimbursement and indemnification.

"(3) The term 'third party' means—

"(A) a State or political subdivision of a State;

"(B) an employer or an employer's insurance carrier;

"(C) an automobile accident reparations insurance carrier; or

"(D) a person obligated to provide, or to pay the expenses of, health services under a health-plan contract.".

(b) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), section 629 of title 38, United States Code, as amended by subsection (a), shall apply to care and services provided on or after the date of the enactment of this Act.

(2)(A) Such section shall not apply so as to nullify any provision of a health-plan contract (as defined in subsection (i) of such section) that—

(i) was entered into before the date of the enactment of this Act; and

(ii) is not modified or renewed on or after such date.

(B) In the case of a health-plan contract (as so defined) that was entered into before such date and which is modified or renewed on or after such date, the amendment made by subsection (a) shall apply—

(i) with respect to such plan as of the day after the date that it is so modified or renewed; and

(ii) with respect to care and services provided after such date of modification or renewal.

(3) For purposes of paragraph (2), the term "modified" includes any change in premium or coverage.

(c) REPORTS.—(1) Not later than six months after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the process for and results of the implementation of section 629 of title 38, United States Code, as amended by subsection (a). Such report shall show the costs of administration (and a detailed breakdown of such costs) and the amount of receipts and collections under such section.

(2) Not later than February 1, 1988, the Administrator shall submit to such Committees a report—

(A) updating the information in the report submitted under paragraph (1); and

(B) providing information on the process and results of such implementation through at least the end of fiscal year 1987.

Subtitle B—Miscellaneous Provisions

SEC. 19031. STUDY OF EFFECT OF VIETNAM EXPERIENCE ON HEALTH STATUS OF WOMEN VIETNAM VETERANS.

(a) REQUIREMENT FOR EPIDEMIOLOGICAL STUDY.—(1)(A) Except as provided in paragraph (2), the Administrator of Veterans' Affairs shall provide for the conduct of an epidemiological study of any long-term adverse health effects (particularly gender-specific health effects) which have been experienced by women who served in the Armed Forces of the United States in the Republic of Vietnam during the Vietnam era and which may have resulted from traumatic experiences during such service, from exposure during such service to phenoxy herbicides (including the herbicide known as Agent Orange), to other herbicides, chemicals, or medications that may have deleterious health effects, or to environmental hazards, or from any other experience or exposure during such service.

(B) The Administrator may include in the study conducted under this paragraph an evaluation of the means of detecting and treat-

ing long-term adverse health effects (particularly gender-specific health effects) found through the study.

(2)(A) If the Administrator, in consultation with the Director of the Office of Technology Assessment, determines that it is not feasible to conduct a scientifically valid study of an aspect of the matters described in paragraph (1)—

(i) the Administrator shall promptly submit to the appropriate committees of the Congress a notice of that determination and the reasons for the determination; and

(ii) the Director, not later than 60 days after the date on which such notice is submitted to the committees, shall submit to such committees a report evaluating and commenting on such determination.

(B) The Administrator is not required to study any aspect of the matters described in paragraph (1) with respect to which a determination is made and a notice is submitted pursuant to subparagraph (A)(i).

(C) If the Administrator submits to the Congress notice of a determination made pursuant to subparagraph (A) that it is not scientifically feasible to conduct the study described in paragraph (1)(A), this section (effective as of the date of such notice) shall cease to have effect as if repealed by law.

(3) The Administrator shall provide for the study to be conducted through contracts or other agreements with private or public agencies or persons.

(b) APPROVAL OF PROTOCOL.—(1) The study required by subsection (a) shall be conducted in accordance with a protocol approved by the Director of the Office of Technology Assessment.

(2) Not later than July 1, 1986, the Administrator shall publish a request for proposals for the design of the protocol to be used in conducting the study under this section.

(3) In considering any proposed protocol for use or approval under this subsection, the Administrator and the Director shall take into consideration—

(A) the protocol approved under section 307(a)(2)(A)(i) of the Veterans Health Programs Extension and Improvement Act of 1979 (Public Law 96-151; 38 U.S.C. 219 note); and

(B) the experience under the study being conducted pursuant to that protocol.

(c) OTA REPORTS.—(1) Concurrent with the approval or disapproval of any protocol under subsection (b)(1), the Director shall submit to the appropriate committees of the Congress a report—

(A) explaining the reasons for the Director's approval or disapproval of the protocol, as the case may be; and

(B) containing the Director's conclusions regarding the scientific validity and objectivity of the protocol.

(2) If the Director has not approved a protocol under subsection (b)(1) by the last day of the 180-day period beginning on the date of the enactment of this Act, the Director—

(A) shall, on such day, submit to appropriate committees of the Congress a report describing the reasons why the Director has not approved such a protocol; and

(B) shall, each 60 days thereafter until such a protocol is approved, submit to such committees an updated report on the report required by clause (A).

(d) OTA MONITORING OF COMPLIANCE.—(1) In order to ensure compliance with the protocol approved under subsection (b)(1), the Director shall monitor the conduct of the study under subsection (a).

(2)(A) The Director shall submit to the appropriate committees of the Congress, at each of the times specified in subparagraph (B), a report on the Director's monitoring of the conduct of the study pursuant to paragraph (1).

(B) A report shall be submitted under subparagraph (A)—

(i) before the end of the 6-month period beginning on the date on which the Director approves the protocol referred to in paragraph (1):

(ii) before the end of the 12-month period beginning on such date; and

(iii) annually thereafter until the study is completed or terminated.

(e) DURATION OF STUDY.—The study conducted pursuant to subsection (a) shall be continued for as long after the date on which the first report is submitted under subsection (f)(1) as the Administrator determines that there is a reasonable possibility of developing, through such study, significant new information on the health effects described in subsection (a)(1).

(f) REPORTS.—(1) Not later than 24 months after the date of the approval of the protocol pursuant to subsection (b)(1) and annually thereafter, the Administrator shall submit to the appropriate committees of the Congress a report containing—

(A) a description of the results obtained, before the date of such report, under the study conducted pursuant to subsection (a); and

(B) any administrative actions or recommended legislation, or both, and any additional comments which the Administrator considers appropriate in light of such results.

(2) Not later than 90 days after the date on which each report required by paragraph (1) is submitted, the Administrator shall publish in the Federal Register, for public review and comment, a description of any action that the Administrator plans or proposes to take with respect to programs administered by the Veterans' Administration based on—

(A) the results described in such report;

(B) the comments and recommendations received on that report; and

(C) any other available pertinent information.

Each such description shall include a justification or rationale for the planned or proposed action.

(g) DEFINITIONS.—For the purposes of this section:

(1) The term "gender-specific health effects" includes—

(A) effects on female reproductive capacity and reproductive organs;

(B) effects on reproductive outcomes;

(C) effects on female-specific organs and tissues, and

(D) other effects unique to the physiology of females.

(2) The term "Vietnam era" has the meaning given such term in section 101(29) of title 38, United States Code.

SEC. 19032. ADVISORY COMMITTEE ON NATIVE-AMERICAN VETERANS.

(a) ESTABLISHMENT OF COMMITTEE.—Not later than May 1, 1986, the Administrator of Veterans' Affairs shall establish an advisory committee to be known as the Advisory Committee on Native-American Veterans (hereinafter in this section referred to as the "Committee").

(b) DUTIES.—The Committee shall examine and evaluate programs and other activities of the Veterans' Administration with respect to the needs of veterans who are Native Americans, including American Indians and Alaska Natives. Such examination and evaluation shall include—

(1) an assessment of the needs of such veterans with respect to health care, rehabilitation, readjustment counseling, outreach services, and other benefits and services under programs administered by the Veterans' Administration; and

(2) a review of the manner in which and the extent to which the programs and other activities of the Veterans' Administration meet such needs.

(c) MEMBERS.—The Committee shall consist of—

(1) the Secretary of Labor (or a representative of the Secretary of Labor designated by the Secretary after consultation with the Assistant Secretary of Labor for Veterans' Employment);

(2) the Chief Medical Director and Chief Benefits Director of the Veterans' Administration or their representatives; and

(3) members appointed by the Administrator from the general public, including—

(A) representatives of veterans who are Native Americans, including American Indians and Alaska Natives and such veterans with service-connected disabilities; and

(B) individals who are recognized authorities in fields pertinent to the needs of such veterans, including the specific health-care needs of such veterans and the furnishing of health-care services by the Veterans' Administration to such veterans.

(d) PARTICIPATION BY OTHER AGENCIES.—The Administrator may invite representatives of other departments and agencies of the Federal Government to participate in the meetings and other activities of the Committee.

(e) NUMBER AND PAY OF MEMBERS.—The Administrator shall determine the number and pay and allowances of the members of the Committee appointed by the Administrator.

(f) REPORTS.—(1) Not later than February 1, 1987, and February 1, 1988, the Committee shall submit to the Administrator a report containing the findings and any recommendations of the Committee regarding the matters described in subsection (b) that were examined and evaluated by the Committee during the preceding fiscal year.

(2) Not later than 60 days after receiving each such report, the Administrator shall transmit to the Committee on Veterans' Affairs of the Senate and House of Representatives a copy of the

report, together with any comments and recommendations concerning the report that the Administrator considers appropriate.

(g) ALASKA NATIVE DEFINED.—For the purposes of this section, the term "Alaska Native" has the meaning given the term "Native" in section 3(b) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(b)).

(h) TERMINATION.—The Committee shall terminate 90 days after the date on which the second report is transmitted by the Committee pursuant to subsection (f)(2).

SEC. 19033. WAIVER OF CONGRESSIONAL NOTICE-AND-WAIT PERIOD FOR ADMINISTRATIVE REORGANIZATION OF CERTAIN VETERANS' ADMINISTRATION AUTOMATED DATA PROCESSING ACTIVITIES.

(a) WAIVER.—The Administrator of Veterans' Affairs may undertake the administrative reorganization described in subsection (b) without regard to the requirements of section 210(b)(2) of title 38, United States Code.

(b) COVERED ADMINISTRATIVE REORGANIZATION.—The administrative reorganization referred to in subsection (a) is a reorganization that—

(1) involves that transfer of certain functions from the Office of Data Management and Telecommunications of the Veterans' Administration to the Department of Veterans' Benefits of the Veterans' Administration; and

(2) is described in letters dated November 1, 1985, that were submitted by the Administrator to the chairmen and ranking minority members of the Committees on Veterans' Affairs of the Senate and House of Representatives.

SEC. 19034. RATIFICATION OF CERTAIN TEMPORARILY EXPIRED AUTHORITIES.

(a) VETERANS' ADMINISTRATION REGIONAL OFFICE IN THE REPUBLIC OF THE PHILIPPINES.—Any action by the Administrator of Veterans' Affairs in providing, during the ratification period, for a Veterans' Administration Regional Office in the Republic of the Philippines under section 230 of title, 38, United States Code, is hereby ratified with respect to that period.

(b) CONTRACT CARE AUTHORITY IN PUERTO RICO AND THE VIRGIN ISLANDS.—Any action by the Administrator in entering into a contract applicable to the ratification period for furnishing care described in subclause (v) of section 601(4)(C) of title 38, United States Code, any action by the Administrator under such contract, and any waiver described in that subclause made by the Administrator that is applicable to that period, is hereby ratified with respect to that period.

(c) ALCOHOL AND DRUG TREATMENT AND REHABILITATION CONTRACT PROGRAM.—Any action by the Administrator in entering into a contract described in section 620A(a) of title 38, United States Code, that is applicable to the ratification period, and any action by the Administrator under such contract, is hereby ratified with respect to that period.

(d) RATIFICATION PERIOD DEFINED.—For the purposes of this section, the term "ratification period" means the period beginning on November 1, 1985, and ending on December 3, 1985.

FLOOR STATEMENT OF SENATOR FRANK H. MURKOWSKI IN SUPPORT OF TITLE XIX OF THE CONFERENCE REPORT ON H.R. 3128, THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (December 19, 1985, with corrections being made in the permanent edition of the Congressional Record)

Mr. MURKOWSKI. Mr. President, I rise today in support of the adoption of the conference report and final passage of H.R. 3128, the Omnibus Budget Reconciliation Act of 1985. As Chairman of the Committee on Veterans' Affairs, I am pleased that the conferees on title XIX of H.R. 3128 regarding veterans' programs have been able to work out a fair and equitable compromise, one which will meet the savings targets required under our reconciliation mandate and which will result in significant reforms in VA health care delivery.

The provisions contained in the conference agreement include the establishment of income eligibility criteria for VA health care, the authorization of reimbursement under health insurance contracts, a 3.1-percent cost-of-living adjustment (COLA) for veterans in receipt of service-connected disability compensation and related benefits, an epidemiological study of the health of women veterans, an evaluation of the needs of Native-American veterans, including Alaska Natives, and a waiver of Congressional notice-and-wait period for administrative reorganization of certain automated data processing functions within the VA.

Both the House- and the Senate-passed bills provided for the establishment of new eligibility criteria and income thresholds for certain non-service-connected veterans and third party reimbursement for non-service-connected veterans who are furnished VA health care. Both the House- and the Senate-passed versions also contained a provision related to the service-connected disability compensation COLA.

Mr. President, I am extremely pleased with the spirit of cooperation and dedication to the resolution of these issues that was evidenced by all the conferees and their staff. I particularly want to thank G.V. (Sonny) Montgomery, Chairman of the House Veterans' Affairs Committee and John Paul Hammerschmidt, Ranking Minority Member of the House Veterans' Affairs Committee and their staffs, as well as Senator Cranston, the Ranking Minority Member of this Committee and his fine staff.

The most significant differences in the House- and Senate-passed bills were found in the policies contained in the proposed income eligibility criteria. The differences were especially significant in how to treat eligibility for VA health care and the level of co-payment that should be required for veterans who were deemed able to pay.

HEALTH-CARE ELIGIBILITY

Mr. President, the revisions proposed by the Senate-passed bill regarding eligibility for VA health care would have prioritized the care to indicate the nation's commitment to service-connected disabled and impoverished veterans. Inpatient and outpatient care would have been prioritized in the same manner, and nursing home care would have been prioritized to ensure that VA nursing care beds would be available first for those who need the highest level of care. The Senate-passed bill would have established an across-the-board income threshold of $25,000 for non-service-connected veterans and would have required the payment of the medicare deductible every 60 days for veterans being furnished hospital care or nursing home care within a one-year period. Veterans who would have been furnished outpatient care and who exceeded the income threshold would have paid 20% of the average cost of a VA outpatient visit.

Mr. President, I believe that although we have moved towards the House's position in many aspects of this bill, the House was also willing to modify its position regarding entitlement to health care as well as the co-payment for those veterans who have non-service-connected disabilities and who do have the ability to contribute towards their care.

Under the conference agreement, nine categories of veterans "shall" be furnished needed hospital care in VA facilities and may be furnished such care, if currently authorized, in non-VA facilities. These categories of veterans would include all service-connected disabled veterans, so-called special statutory categories (including POW's, veterans exposed to Agent Orange or radiation and veterans of World War I and earlier conflicts) as well as other non-service-connected veterans with incomes not exceeding $15,000 for a veteran with no dependents and $18,000 for a veteran with one dependent, plus $1,000 for each additional dependent. By establishing a new "shall" category for these veterans seeking hospital care the Congress has indicated its strong feeling that these categories of veterans should have the highest priority and that they should be furnished needed care to the extent that beds are available and funds have been appropriated. The Statement of Managers indicates that the conferees clearly intend that for the above-mentioned categories, the VA's "sole obligation is (1) if a veteran is in immediate need of hospitalization, to furnish an appropriate bed at a VA facility where the veteran applies, or if none is available there, to furnish a contract bed if authorized in section 603 or arrange to admit the veteran to the next closest VAMC, or DOD facility with which the VA has a sharing agreement, with an available bed; or (2) if the veteran needs non-immediate hospitalization, to schedule the veteran for admission where the veteran applied, if the schedule permits, or refer the veteran for scheduling and admission to the nearest VAMC, or DOD facility with which the VA has a sharing agreement, with an available bed and facilitate the veteran's admission there." That is the extent to which current law would be modified with respect to the word "shall". The reason that the conferees included this language in the Statement of Managers was to make perfectly clear that although we have taken a

major step in requiring the VA to care for these high priority categories of veterans, the VA is not expected to plan additional or expanded services or space to care for such veterans. We believe the VA does have the capacity to treat these nine categories. If such a veteran applies and there is no space, the conferees expressed the view that the VA will make every attempt to ensure that such a veteran will be treated at another VA facility that provides similar services. This legislation would not change current law or practice regarding the beneficiary travel program. I wish to emphasize that the intent of having veterans referred from one hospital to another was not to increase the cost to beneficiary travel but to increase the possibilities that veterans would receive needed care as soon as possible. There is no requirement that beneficiary travel be paid in such instances.

A concern has been raised that using the word "shall" would create an entitlement to VA care that would circumvent the appropriations process. The VA's General Counsel has informed us that no such entitlement would be created. I ask unanimous consent that the General Counsel's "white paper" on this eligibility issue be included in the Record at this point.

PROPOSED AMENDMENTS TO SECTIONS 610 AND 612—IS AN "ENTITLEMENT" CREATED?

Both the House and Senate versions of the Budget Reconciliation Act (H.R. 3500 and S. 1730) contain the so-called "means test/third party reimbursement" legislation which would alter the eligibility of veterans to receive VA health care benefits. Both the House and Senate bills would amend 38 U.S.C. §§610 and 612, to provide that the Administrator "shall furnish" hospital care and outpatient medical services to certain veterans. The Senate bill also provides that nursing home care "shall" be furnished to those same veterans. Under existing law, the Administrator "may furnish" such care. Both bills also delete existing language in sections 610 and 612 providing that care may be furnished only within the limits of VA facilities. The changes made by these bills have given rise to the question: Will certain veterans be "entitled" to receive VA health care benefits, and what does that mean?

Generally, the term "entitlement" connotes a right to receive something, or to do something, with the scope of the right varying according to the legal authority creating it. See generally Words and Phrases, Volume 14A, pages 388–395 (1952 ed) and Supp. pg. 18 (1985). Entitlements may take other forms, but this paper is primarily concerned with what may be characterized as "statutory entitlements."

A review of the case law reveals that the terms "entitlement" and "statutory entitlement" are used very loosely and imprecisely by the courts. Research has not revealed an instance of a court's defining the terms specifically. However, based on a review of cases using the term "entitlement" this paper posits the following definition. "Statu-

tory entitlement," is a right, not subject to the discretion of an agency official, to receive a payment, a good, a service, or some other right from the government on the basis of meeting eligibility criteria established by statute or implementing regulations. As discussed below, however, the identification of an interest in a benefit as a statutory entitlement does not in itself indicate that the "entitled" parties have an absolute right to, and can enforce receipt of, that benefit.

The concept of a statutory entitlement appears to embody two principal elements: first, the right must be defined in a law or regulation, and, second, the law or regulation must leave little if any discretion to government officials to determine whether or not the benefit will be provided. The term "entitlement" is most commonly used in the case law in the context of constitutional procedural due process cases involving individuals or groups seeking to show the presence of a "property interest" which cannot be abridged except by due process of law. Thus in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), the court stated that welfare benefits "are a matter of statutory entitlement for persons qualified to receive them." Id. at p. 262. In *Board of Regents* v. *Roth*, 408 U.S. 564 (1972), the court states that to have a property interest, an individual must have "a legitimate claim of entitlement." *Id.* at 577. The *Roth* court clearly stated that a property interest or "entitlement" is defined by the source that created the interest. Thus, the court stated:

> Thus, the welfare recipients in *Goldberg* v. *Kelly*, supra, had a claim of entitlement to welfare payments that was grounded in the statute defining eligibility for them. Id at 577.

There is some case law to suggest that a statute or regulation which vests significant discretion in government officials in connection with provision of the benefit does not confer an entitlement. In *Ingram* v. *O'Bannon*, 534 F. Supp. 385 (E.D. Pa. 1982), a case in which plaintiffs claimed an absolute right to benefits, the court held that no entitlement existed where, despite language in the state's regulation defining eligibility for services on the basis of specific financial and medical need, other regulatory provisions vested broad discretion in Agency officials to determine how benefits would be provided. Indeed, the statutory scheme and applicable regulations in that case allowed the state to define the entitlement as permitting the decision by State officials to determine provision of the benefit under priority lists which, in fact, denied the benefit to individuals otherwise meeting eligibility criteria. *Id.* at 389. Consequently, the Court stated, "This regulations (sic) negates any allegation that when demand surpasses availability, applicants have a legitimate expectation that the state will increase funding of the program to ensure that all applicants receive the service." *Id.* The statutory

scheme did "not create an entitlement to the service or at most, create[d] an entitlement to receive the service as it is available." Id. Similarly, in *Riverview Investments* v. *Ottowa Community Investment Corp.*, 769 F.2d 324, 327 (6th Cir. 1985), the court held that the substantial discretion vested in State officials to administer a program (municipal bond) defeated any claim to an entitlement to have such bonds issued, even though other applicants had received the benefits of the issuance of the bonds. See also *Moore* v. *Johnson*, 582 F.2d 1228 (9th Cir. 1978). Contrast *Alexander* v. *Polk*, 572 F. Supp. 605 (E.D. Pa. 1983), a case in which plaintiffs claimed an entitlement to benefits to the extent funding is available. There the court held that an entitlement existed in a statutory supplemental food benefit program, to the extent funds were available, even though officials had authority to limit the benefit when adequate funds were not available to provide the benefit to all eligible individuals. While the *Polk* case demonstrates that the law is by no means certain with respect to what constitutes a property interest establishing a right to due process, it does not suggest that a statutory entitlement is an absolute right to that property.

The question has been posed as to whether the proposed amendments to sections 610 and 612 of title 38, United States Code, in the House and Senate Budget Reconciliation bills, create entitlements. In determining precisely what benefits are granted by the statute, and whether the individual is statutorily entitled to them, attention must be paid to all of the statutory limitations on the grant of the benefits. Existing sections 610 and 612 use the words "may furnish" in describing the Administrator's authority to provide health care benefits to veterans. Those words are susceptible to an interpretation that the Administrator has virtually unlimited discretion to determine whether or not to provide care or services to eligible veterans. That interpretation was supported in an opinion prepared by the Office Of Legal Counsel, Department of Justice, dated December 7, 1982. The proposed changes to sections 610 and 612 would certainly alter and limit the Administrator's discretion to decide not to provide care to certain categories of veterans, but the changes do not foreclose all discretion, or "entitle" every otherwise eligible veteran (who "shall" be provided care) to received whatever care or services are deemed desirable or even determined necessary. Generally speaking, we believe the proposed change from "may" to "shall" would only mandate that if VA facilities and resources are *available* and *capable* of providing *needed* care and services, the Administrator must furnish the care and services to any eligible veteran able to present himself or herself at the VA facility to receive the care.

The major limitation on the provision of benefits is the fact that VA facilities and resources are limited. At the present time, facilities simply do not exist to provide all

types of health care benefits to all veterans eligible to receive those benefits, particularly under the House bill, and both the Senate and House bill continue to impose stringent limitations on the provision of contract care in non-VA facilities. Furthermore, VA's ability to acquire or construct new medical facilities is constrained by statutory provisions. For example, any significant VA construction project must be approved by the Congress pursuant to 38 U.S.C. § 5004, before money may be appropriated for the project. Finally, as discussed below, the proposed bills do not create new spending authority (entitlement authority) such that one might argue (not necessarily successfully) that Congress must appropriate funds to construct facilities to meet the needs of all eligible veterans. Accordingly, under the House bill, for example, VA will be able to provide care and services within the limits of its facilities and resources, and eligible veterans can have no clear assurance of *receiving* needed care in every instance.

In addition to the basic availability of resources limitation, both the House and Senate bills grant, or leave in place a significant breadth of discretion in the Administrator to determine whether to provide all eligible veterans with health care benefits. First, the care sought by a veteran must be "needed" by the veteran (House bill) or "reasonably necessary" (Senate bill). VA regulations and manual provisions treat this eligibility criteria in essentially absolute terms, i.e., a veteran either does or does not need medical care. However, the requirement that care be needed can also be viewed, particularly under the pending House bill, (which on its face places all but nor.-needy, nonservice-connected veterans on an equal footing as to eligibility and priority for care in VA facilities) as permitting the Administrator to assess need in relative terms, e.g., degree of urgency of need in relation to VA capabilities. Thus, if resources are extremely limited, the Administrator could conceivably determine that only limited types of health care services can be said to be "needed." If an outpatient clinic is full, perhaps only emergency services could be deemed "needed" for a new applicant.

Additionally, neither the House nor the Senate bill alters the existing language of 38 U.S.C. § 621. That section grants the Administrator authority to promulgate regulations governing, and limiting, hospital, nursing home, and domiciliary care. Section 621 is generally thought of as granting necessary authority to allow efficient administration of the medical system. However, it grants significant discretion to the Administrator to determine that care will not be provided in certain instances. In instances where VA lacks the capacity or facilities to meet the demand for health care benefits, this authority would, for example, allow the Administrator, under the House bill, to deny immediate care to certain categories of veterans, and place them on waiting lists for care in the future. (The Senate bill provides specific priority provisions, of course.)

It should also be noted that the House bill proposes to add a new subsection (g) to section 610. This new provision would explicitly recognize the Administrator's existing discretion "to determine—

(A) the appropriateness of furnishing medical services, therapies, or programs under this chapter; or

(B) in what manner they will be furnished.

A veteran seeking care from the VA can only expect to receive the care and services authorized by the law. Clearly the "entitlement" to be enjoyed by the beneficiaries of these bills is encumbered by significant limitations. Although individuals have used the word "entitlement" to describe the benefit that the House-passed measure would provide, we find no basis to conclude that individual non-service-connected veterans, e.g., can have more than a unilateral expectation of receiving VA care whenever they need it. Although we do not foresee the likelihood that service-connected veterans under the Senate bill would be denied needed VA care, it also is not clear that veterans can compel the Agency to provide care as a matter of statutory entitlement.

As a final matter, we address the question of whether the proposed changes to sections 610 and 612 would invoke any legal requirement that the Congress appropriate funds sufficient to assure that VA facilities would be constructed and resources made available to provide health care benefits to all eligible veterans who seek them. We do not believe the changes invoke any such authority.

Under the Congressional Budget Act of 1974, Congress may create what is termed "entitlement authority." Entitlement authority is defined in section 401(c) of the Act (2 U.S.C. § 651(c)(2)(C)) as the authority:

> (C) to make payments (including loans and grants), the budget authority for which is not provided for in advance by appropriation Acts, to any person or government if, under the provisions of the law containing such authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by such law.

The language in the above provision, "the United States is *legally obligated* to make such payments," (Emphasis added), implies that the funds must be paid to beneficiaries, and that funds for payment must be appropriated by the Congress. In our view, however, neither the proposed House or Senate changes to sections 610 and 612 would create entitlement authority, so no legal obligation can arise. The first element in the definition of entitlement authority is met in that VA health care benefits are authorized by sections 610 and 612, not by appropriations acts. However, the other statutory elements of entitlement authority are not. First, health care benefits are not payments, they are services. Second, there are limitations and

areas of discretion on the provision of the health care benefits, as discussed above, not provided in the authorizing law. An individual cannot expect and is not assured of receiving the sought after benefits simply by meeting the statutory eligibility requirements.

Even if we assume that the amendments to sections 610 and 612 were to create entitlement authority, or a statutory entitlement, we question whether that would absolutely require the Congress to appropriate funds to meet the obligation. In fact, Congress might actually decide to terminate an entitlement program by failing to provide funds. Thus, in *Local 2577 AFGE* v. *Phillips,* 358 F. Supp. 60 (D.D.C. 1973), the court noted:

> An authorization does not necessarily mean that a program will continue. Congress, of course, may itself decide to terminate a program before its authorization has expired, either indirectly by failing to supply funds through a continuing resolution or appropriation, or by explicitly forbidding the further use of funds for the programs * * * Id. at 75.

Relying on that case, our office has held that a statutory entitlement is limited by the availability of the necessary appropriations.

The Statement of Managers also includes language to highlight the intent that the Congressional Budget and Impoundment Control Act of 1974 would continue to apply. Under this legislation the use of the term "shall" is intended to enhance the eligibility of the specified veterans but not intended to diminish the status of all other categories of veterans eligible for care under current law. The VA would continue to be required to provide such needed care to all eligible veterans if resources have been appropriated and remain available. But the use of the term "shall" does not require that any specified level of appropriations be made and it is certainly my intent to underline that an entitlement as defined under the Congressional Budget Act has not been created.

Except for those deemed able to defray the cost of care, other non-service-connected veterans will continue to have the same eligibility for health care as under current law, except that for veterans age 65, and older, age would no longer be the only factor in determining eligibility. The VA will continue to have discretionary authority to treat them on a space-available basis. Non-service-connected veterans with incomes above $20,000 for a single veteran and $25,000 for a married veteran with one dependent, plus $1,000 for each additional dependent will be furnished care on the basis of an agreement to make a modest co-payment, and if resources and facilities are otherwise available. The conferees categorically rejected the Administration's proposed means test and spend down theory in favor of a more equitable and less onerous approach which grants access to health-care irrespective of income.

Mr. President, under the conference agreement, outpatient care and nursing home care eligibility would remain the same as cur-

rent law. I greatly regret that the House would not accept the Senate's provisions to prioritize eligibility for both inpatient and outpatient care. In my view, such an approach clearly would have provided service-connected and impoverished veterans with the highest priority for care.

Mr. President, in initiating a co-payment for veterans who have been determined able to contribute a modest amount to the cost of their care, the conferees have taken a major step in redefining the parameters of VA care for certain non-service-connected veterans. It is important to remember that this country owes a great debt to veterans who served and sacrificed for their country. This legislation ensures care for veterans with service-connected disabilities and impoverished veterans. However, we also have to remember that resources are not unlimited and we face enormous deficits. The recent enactment of the so-called Gramm/Rudman balanced budget amendment certainly emphasizes the fact that the Congress and the country recognize the need to control spending and have taken an important step toward that end. I believe that this legislation responsibly meets the level of savings required of both the Senate and House Veterans' Affairs Committees.

The Administration's original proposal for a means test contained an $11,400 income cut-off for a single veteran and required a strict spend down of income by veterans above this threshold prior to becoming eligible for medical care. That approach was rejected by both the House and the Senate. Instead, we have income thresholds which are more realistic in terms of family income standards, and we have incorporated provisions which permit veterans with incomes over that threshold to use the VA if facilities and resources are available based on an agreement to contribute towards their care. The income threshold agreed to by the conferees combines both the Senate's across-the-board $25,000 threshold and the House's approach of having different thresholds for single and married veterans. These thresholds are clearly spelled out in the Statement of Managers accompanying the conference agreement.

Mr. President, under the conference agreement, a veteran being furnished hospital care and who is deemed not unable to defray the expense of care, would be required to pay the Medicare deductible, currently $492, for the first 90 days, and half of that deductible for each succeeding additional 90 days of care, within a 12-month period. The medicare deductible would apply for each 90 days of care for veterans who are furnished VA nursing home care. The conference agreement does provide, however, that if the veteran has been transferred from a VA hospital to a nursing home, the veteran's initial $492 payment would apply for the nursing care until the expiration of the 90-day period. For outpatient and home-health care, veterans deemed able to pay would contribute a per visit payment of 20% of the VA average daily rate not to exceed the medicare deductible for each 90 day period. All of the inpatient payments during each 90 day period would count towards the outpatient cap. The same policy would apply regarding outpatient co-payments—they would count towards the inpatient care.

The adoption of income eligibility criteria is not only a reflection of the budgetary constraints facing the Congress, but also a commitment to continue to care for the nine categories of veterans de-

fined by this legislation and an endorsement of the continuation of a comprehensive VA health-care system by allowing non-service-connected veterans with higher incomes to continue to have access to the VA system in return for a small partial payment.

THIRD PARTY REIMBURSEMENT

Mr. President, H.R. 3128 contains a provision, which for the first time, would achieve parity between the VA and private health care providers. The legislation would authorize, prospectively, reimbursement to the Federal Government under health-insurance contracts for the reasonable costs of health care and services furnished by the VA to non-service-connected veterans who have health insurance. Most health insurance plans and contracts contain exclusionary clauses which bar reimbursement to the United States for care provided by the VA. Recoveries under this provision are not intended in any way to reduce the annual appropriation for the VA health care system as all recoveries will be deposited into the U.S. Treasury. Both the House and the Senate have agreed on the basic policy on this issue and agree that a veteran who is otherwise insured must be allowed to use those insurance benefits for VA care as well as for private care.

The provisions contained in the Senate and House reconciliation bills were very similar. The conference agreement incorporates the essence of both the Senate and House provisions, several of which I would like to highlight.

The Administrator would be required to prescribe regulations which would govern the determination of the reasonable cost of care or services.

The regulations to be prescribed for determining the reasonable cost of care or services shall also provide that the determination of "reasonable cost" may not exceed an amount equal to that which the third party would pay for such care or services under prevailing rates of payment to non-Federal facilities in the same geographic area as the VA facility in which the care or services are furnished.

The establishment of a so-called third party reimbursement would not, in any way, restrict an eligible veteran's access to VA health-care, nor would it require a veteran to pay any deductible or co-payment required under the terms of an insurance contract in order to receive care.

The law would also specify that a veteran's failure to pay a deductible or co-payment required under the terms of an insurance contract would not preclude the government from recovering from the third party; however, the amount of the recovery would be reduced by the amount(s) of the deductible or co-payment. This provision would also authorize, subject to certain restrictions, a third party to inspect medical records of a health-plan beneficiary for whom recovery is sought, in order to enable the third party to verify that the care or services were funished and meet the criteria generally applicable under the health-plan contract.

Finally, the VA would also be required to submit to the Congress, reports on the implementation and results of the amendments made under this provision.

The third-party reimbursement provision contained in the conference agreement reflects certain recommendations made by private health insurers, concerning the constitutionality of such a provision with respect to existing insurance contracts, and the adequacy of cost-containment measures within the VA health-care system.

SERVICE-CONNECTED DISABILITY COMPENSATION COLA

[NOTE.—The service-connected disability compensation COLA provisions were deleted from the final version of the reconciliation bill and were passed in a separate bill which has been enacted in Public Law 99-238.]

ADMINISTRATIVE REORGANIZATION

In April 1985, the VA Administrator selected McManis Associates Inc. to prepare an implementation plan for the moderization of the Department of Veterans' Benefits (DVB) information management systems. Their plan was released on October 25, 1985. It suggested certain reforms for the modernization of the current benefits delivery system. Based upon this report, the Administrator has proposed a reorganization of certain automated data processing functions. In a letter to me, as Chairman of the Senate Veterans' Affairs Committee, dated November 1, 1985, (which I ask unanimous consent be inserted in the record), the Administrator has requested a waiver of the "notice and wait" period required by section 210(b)(2) of title 38, United States Code.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

NOVEMBER 1 1985

Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

The purpose of this letter is to report a planned administrative reorganization within the Veterans Administration (VA) involving the transfer of certain functions from the Office of Data Management and Telecommunications (ODM&T) to the Department of Veterans Benefits (DVB).

As you are aware, under the Congressional "report and wait" requirements of 38 U.S.C. § 210(b)(2), a detailed plan and justification must be submitted to the appropriate committees of Congress for certain VA administrative reorganizations involving a reduction during any fiscal year by 10 percent or more in the number of full time equivalent employees (FTEE) at a VA covered office or facility. The report must be made not later than the date on which the President submits his budget for the next fiscal year. Thereafter, no action can be taken to implement the reorganization until the first day of that fiscal year. This letter is submitted in order to satisfy the above-reporting requirement for a planned VA organizational transfer of certain automated data processing (ADP) functions as described below.

As you are aware, in April 1985, the Veterans Administration selected McManis Associates, Inc., to prepare an implementation plan to modernize the DVB benefits and services delivery systems. This plan was to be consistent with my policy statement mandating the full modernization of the Agency's data processing and communications systems so as to improve the quality of service provided to veterans and their families. The McManis study among other things found that there was limited end-user involvement in system design and development, limited systems training, and that there were inconsistent system utilization management practices. Based on these findings, I approved the McManis recommendations that DVB should have the authority, resources and responsibility for the systems development and greater operational oversight

within overall agency standards and policy guidelines. Implementation of this recommendation requires the administrative reorganization which is the subject of this letter.

We propose to reorganize in order to move ADP program specialists closer to the DVB program specialists, and give DVB a greater role in ADP decisions. By giving DVB control of ADP resources, they will be able to better focus ADP expenditures on service delivery priorities. This reorganization will involve 362 ODM&T full time equivalent employees (FTEE). These organizational transfers will occur at VA Central Office (VACO), and at the Austin, Texas; Hines, Illinois; and Philadelphia, Pennsylvania VA Data Processing Centers (DPC). The number of FTEE transferred as the result of this reorganization and the base 1986 ODM&T FTEE at each facility, are as follows: VACO--81/441; Austin--75/663; Hines--146/406; and Philadelphia--60/197.

The functions performed in the positions to be transferred are unique to the support of DVB programs and, after this transfer to DVB, ODM&T will no longer perform these functions. These functions, and the stations at which they are performed, are as follows: VACO--Benefits Automation Service, which designs all ADP programming for DVB, and some administrative support personnel; Austin DPC--Benefits Delivery System Division, which does programming for DVB in the areas of loan guaranty, the Beneficiary Identification and Records Location Subsystem (BIRLS), and debt collection (beginning in fiscal year 1986); Hines DPC--System Support Divisions, which handle programming for DVB benefits programs, such as Compensation and Pension, Education, and Vocational Rehabilitation, and which prepare the computer tapes for the Department of Treasury to use in issuing benefits checks; and Philadelphia DPC--Systems Division, which does programming for VA applications. There will also be transferred, at each of the above stations, the functions of that part of the systems verification and testing element which performs systems quality control for the programming done by the benefits delivery system staff at each of these stations.

It is clear from the foregoing that this reorganization is simply an organizational transfer of employees. These employees will not be relocated to other stations. The great majority of them will experience no change in their functions, personnel status, immediate supervision, or even in the location of their workspace. Accordingly, there will be little or no cost impact as the result of this reorganization.

We believe that this reorganization is appropriate and advisable, and that it will have the desired effect of improving and making more efficient DVB benefits delivery systems by giving DVB direct control over the resources used for its ADP support. This reorganization has already been the subject of DVB briefings with staff of the House and Senate Veterans' Affairs Committees. Of course, we would be pleased to provide any additional information which you may desire concerning this reorganization.

I request your assistance in introducing, and supporting enactment of, a legislative waiver of the 38 U.S.C. § 210(b)(2) waiting period for this reorganization, so that these improvements in our organizational structure can be made as soon as possible. Suggested language for such a legislative waiver is enclosed. Absent such a waiver, we must wait until fiscal year 1987 to implement this reorganization.

I appreciate your support for our efforts to improve benefits delivery for our Nation's veterans.

Advice has been received from the Office of Management and Budget that there is no objection to the presentation of this letter and legislative proposal from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez, Jr. Deputy Administrator • For
HARRY N. WALTERS
Administrator

Enclosure

Under current law the VA may not, in any fiscal year, implement a reorganization involving more than a 10 percent reduction in the number of full time equivalent employees at any VA facility with more than 25 employees unless the Administrator, not later than the date on which the President submits the budget for that year, provides "a report containing a detailed plan and justification for the reorganization." The "notice and wait" provisions of section 210(b)(2) of title 38 would delay the implementation of the proposed reorganization until the next fiscal year. This bill would provide a waiver of the "notice and wait" requirement so that VA may proceed immediately with the proposed reorganization.

I strongly believe that DVB does have data processing problems which require immediate attention. This waiver would allow the VA to reorganize immediately and to proceed with the process of implementing needed reforms. I believe giving those responsible for VA benefit payments authority over the data processing resources is a first step in the reforms necessary to improve VA data processing. The General Accounting Office (GAO) is studying VA's data processing capabilities as well as the recommendations of McManis Associates. GAO has informally expressed concerns about hardware and software procurement plans recommended by the McManis Study and the lack of comprehensive data processing planning on the part of the VA. I endorse the proposed reorganization in the belief that it will establish a structure conducive to reform. However, in doing so, I strongly urge the VA Administrator, Harry Walters, to work with the Committee and the GAO to ensure that data processing reforms are well thought out and carefully planned. I will be monitoring closely DVB's progress in improving its data processing systems to meet the Agency's and the Congress' needs for timely and accurate information in the most cost effective and efficient manner.

SAVINGS ESTIMATE

The Congressional Budget Office has indicated that total savings from the enactment of the income eligibility criteria, third party reimbursement, and the 3.1% COLA will be in excess of $1.26 billion over the next three years, which is more than $100 million more than our mandated reconciliation savings. These savings have been achieved without the reduction of any program or service to our Nation's veterans and will, in fact, serve as a model for the commitment of the Nation to continuing to provide needed health care to eligible veterans.

CONCLUSION

In closing, I want to note, once again, my thanks to my distinguished counterpart on the House Veterans' Affairs Committee, Sonny Montgomery, as well as Alan Cranston and John Paul Hammerschmidt, the Ranking Members of the Senate and House Veterans' Affairs Committees. The staffs have worked hard and very closely to resolve the small details, as well as some rather large policy differences on certain issues, to come up with a very fair and well balanced compromise. I especially want to thank Mack Fleming, Chief Counsel of the House Veterans' Affairs Committee, his

staff Pat Ryan, Jack McDonnell, Victor Raymond, Arnold Moon and Charles Peckarsky; as well as Rufus Wilson, the Minority Chief Counsel of the House Veterans' Affairs Committee and Kingston Smith; Jon Steinberg, Senator Cranston's Chief Counsel and his fine staff, Ed Scott, Bill Brew, Babette Polzer, Nancy Billica, and Ingrid Post, who is one of the most dedicated workers I know of in the Senate. A special thanks to Bob Cover, House Legislative Counsel, who labored tirelessly to perfect the bill language. Last, but certainly not least, I want to thank my own fine staff headed by Anthony Principi, Chief Counsel, and including Julie Susman, Cathy McTighe, Cynthia Alpert, Chris Yoder, Lisa Moore, Judy Boertlein, Jody Sanders and Kay Eckhardt. Mr. President, I urge the adoption of the conference report and final passage of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Mr. President, I ask unanimous consent that the Statement of Managers on Title XIX be included at the appropriate place in the record.

FLOOR STATEMENT OF SENATOR ALAN CRANSTON IN SUPPORT OF TITLE XIX OF THE CONFERENCE REPORT ON H.R. 3128, THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (December 19, 1985, with corrections being made in the permanent edition of the Congressional Record)

Mr. CRANSTON. Mr. President, as the ranking minority member of the Committee on Veterans' Affairs, I would like to explain and discuss the provisions of title XIX of the pending measure, which pertain to Veterans' Administration programs, so as to provide background for my colleagues and others with an interest in the actions of our Committee and our counterpart Committee in the House to satisfy our reconciliation instructions as set forth in the First Concurrent Resolution on the Budget for FY 1986, S. Con. Res. 32.

At the outset, I note the very difficult task that our two Committees had in developing this conference agreement. We were working with very complex subject matter, and the differences between the two Houses on some issues were great. However, by virtue of long and hard negotiations between conferees and the staffs of the two Committees, we were finally able to reach a compromise which is reflected in the provisions in title XIX of the pending measure.

As with all compromises, the final agreement of the conferees is not completely satisfactory to either side, but I believe that the Senate's positions and concerns were fairly vindicated. I thank my fellow Senate conferees, our Committee Chairman (Mr. Murkowski), and our former Chairman (Mr. Simpson). I congratulate our colleagues in the other body who served as conferees, particularly Representative Montgomery, the House Committee Chairman, Representative Hammerschmidt, the Committee's Ranking Minority Member, and Representative Edgar, the Chairman of the Subcommittee on Hospitals and Health Care, for their steadfast dedication to the House position.

Mr. President, at the time the reconciliation legislation was before the Senate last month, I made a detailed statement on the legislation our Committee developed to meet our reconciliation instructions. I refer my colleagues and others with an interest in this background information to those remarks which begin on page S15468 of the Congressional Record of November 14, 1985.

SUMMARY OF TITLE XIX AND RECONCILIATION SAVINGS

Mr. President, as I noted when the reconciliation legislation was before the Senate in November, our Committee's proposed legislation—which was included in title XI of the Senate reconciliation bill, S. 1730—was composed of three parts, one revising VA health-care eligibility criteria, one authorizing the VA to recover from third-party insurers for care provided to veterans with health in-

surance and with no service-connected disabilities, and the last, placing a cap on the amount of the FY 1986 VA disability compensation COLA. In the conference agreement, Subtitle A of title XIX, entitled "Health Care", contains provisions derived directly from the first two parts, Subtitle B, entitled "Compensation Rate Increase", contains a compensation COLA rate increase below the cap we had set, and Subtitle C, entitled "Miscellaneous Provisions", contains four additional provisions, two of a technical nature and two derived from provisions in the House-passed reconciliation measure for which the Senate had passed a counterpart provision in another measure, S. 1887.

Briefly, title XIX consists of the following elements:

—Subtitle A would revise certain health-care eligibility criteria and establish a requirement for certain non-service-connected disabled veterans to make modest payments for VA care, and provide for recovery from health insurers of certain reasonable costs of VA-furnished care and services for veterans with health insurance coverage and with no service-connected disabilities;

—Subtitle B would provide, effective December 1, 1985, for a 3.1-percent cost-of-living increase for FY 1986 in VA disability compensation and DIC rates; and

—Subtitle C would (1) require the VA to provide for the conduct of a female Vietnam veteran health-experience study, (2) establish a VA Advisory Committee on Native-American Veterans, (3) waive a waiting period for an administrative reorganization within the VA, and (4) ratify certain temporarily-expired authorities.

More specifically, the three elements which result in cost savings (two in Subtitle A and one in Subtitle B) fulfilling—indeed, as I have noted, exceeding substantially—our reconciliation instructions would provide as follows:

REVISION OF HEALTH-CARE ELIGIBILITY

Subtitle A.—First, would revise VA health-care eligibility so as to direct—by using the word "shall" in describing access to VA care rather than the word "may" as used in current law—that VA-furnished hospital care be furnished to specified categories of veterans: namely (1) any veteran for a service-connected disability; (2) a veteran with a service-connected disability rated at 50 percent or more; (3) a veteran with a service-connected disability rated at less than 50 percent (including a veteran discharged for a disability incurred or aggravated in the line of duty or a veteran disabled as a result of VA treatment or vocational rehabilitation); (4) a veteran who is a former prisoner of war; (5) Vietnam veterans exposed to certain toxic substances or veterans exposed to radiation from nuclear detonations; (6) veterans of the Spanish-American War, Mexican Border period, or World War I; and (7) a veteran without a service-connected disability who meets a new, first-level income threshold, to be called the "Category A Threshold", by virtue of having annual family income no greater than $15,000 for a veteran with no dependents and $18,000 for a veteran with one dependent, with adjustments of $1,000 for additional dependents; and would

eliminate the existing eligibility of non-service-connected veterans over age 65 without regard to their ability to defray the cost of their care.

Second, would generally maintain the current law authorities to furnish hospital care through contract or fee-basis arrangements with non-VA facilities and nursing home and outpatient care, either in VA or non-VA facilities as authorized, to the extent of available resources and facilities, to veterans in the categories mentioned above.

Third, would generally maintain current law authorities to furnish hospital and other forms of care, to the extent of available resources and facilities, to veterans who meet a new, second level income threshold, to be called the "Category B Threshold", by virtue of having annual family incomes no greater than $20,000 for a veteran with no dependents and $25,000 for a veteran with one dependent, with adjustments of $1,000 for additional dependents, either in VA facilities or, as currently authorized in certain circumstances, through non-VA facilities at VA expense.

Fourth, would authorize the VA to furnish, within otherwise available space and resource capacity, care to veterans without service-connected disabilities and whose annual family incomes exceed the Category B threshold who agree to make certain payments—approximating payments made under Medicare—in connection with their care.

The Congressional Budget Office estimates that the provisons relating to health-care eligibility criteria in this subtitle would generate net reconciliation savings of $49 million in budget authority (BA) and $46 million in outlays in FY 1986, $93 million in BA and $87 million in outlays in FY 1987, and $102 million in BA and $95 million in outlays in FY 1988.

THIRD-PARTY REIMBURSEMENT

Subtitle A would also authorize the United States to collect from third-party insurers the reasonable cost of care provided by the VA to non-service-connected-disabled veterans to the extent that the insurer would be liable to pay for the care if it had been furnished by a private facility. These provisions would have the effect of invalidating the so-called "exclusionary clauses" in health insurance contracts, which currently preclude payment for care furnished by federal facilities, and would make the VA eligible to receive payment from a third party on the same basis and to the same extent that a non-VA health-care facility would be eligible. The VA's right to recover would, therefore, generally be contingent upon the agency's compliance with the terms and conditions of the law, contract, or other arrangement under which the veteran would be eligible for payment by the third party.

CBO estimates that these so-called "third-party" provisions in subtitle A would generate net BA and outlay savings of $203 million in FY 1986, $353 million in FY 1987, and $402 million in FY 1988.

VA COMPENSATION COLA

Subtitle B.—Would provide, effective December 1, 1985, for a VA disability compensation COLA of 3.1 percent in FY 1986—the same percentage COLA that was provided in FY 1986 for VA pension and Social Security—as compared to 4.1 percent, as assumed in the CBO baseline.

CBO estimates that the provisions in subtitle B would produce savings of $84 million in BA and $76 million in outlays in FY 1986, $102 million in both BA and outlays in FY 1987, and $104 million in both BA and outlays in FY 1988.

TOTAL THREE-YEAR RECONCILIATION SAVINGS

Altogether, then, CBO estimates that title XIX would produce savings of $336 million in BA and $325 million in outlays in FY 1986, of $548 million in BA and $542 million in outlays in FY 1987, and $608 million in BA and $601 million in outlays for FY 1988, for total 3-year savings of $1.492 billion in BA and $1.468 billion in outlays, $342 million in BA and $318 million in outlays in excess of our reconciliation instructions to save $1.15 billion in BA and outlays over those 3 years.

BACKGROUND

Mr. President, I wish to emphasize, as I did during Senate debate on the reconciliation legislation last month, that I concur wholeheartedly that there is an absolutely critical need to restrain Federal spending so as to make major reductions in the deficit. Although I did not support the conference report on the budget resolution—I voted for an alternative that would have made a deeper cut in the deficit—a majority of my colleagues in both Houses did support the conference report.

Under the budget resolution that the Congress adopted, our Committee and our counterpart Committee in the other body were mandated to act to find ways to achieve a specified level of savings. It is essential, in understanding our two Committees' actions, to appreciate that if we had not met our obligations in this regard, the Budget Committees in our respective bodies would have done so. I want to stress that point to my colleagues and to others with an interest in this legislation.

In light of this background, I did my best to work in a cooperative fashion with the seven other members of our two Committees who served as conferees on this legislation, and I believe that we succeeded in developing legislation that allows us to satisfy our reconciliation instructions in an appropriate fashion. In fact, as I have indicated already, the legislation that we have developed would save $342 million more in BA and $318 million more in outlays than the required amounts over the next three fiscal years, and $176 million in BA and $171 in outlays more than in either version of the legislation. Those added savings are due to the lower-than-anticipated inflation rate reflected in the Consumer Price Index increase as calculated for purposes of the Social Security cost-of-living adjustment (COLA) and applied in this measure to the VA compensation COLA.

I want to stress, however, that this compromise, as did the Senate measure, would achieve the mandated savings without requiring reductions in VA programs.

Specifically, in FY 1986, $227 million in BA and outlay savings would come from added revenues to the Federal Government—a net of $203 million of which would be from third-party health insurers and a net of $24 million from small copayments from non-service-connected veterans with annual family incomes over the $20,000/$25,000 Category B threshold in connection with their being furnished VA care. In addition, the CBO estimates that net savings of approximately $26 million in BA and $23 million in outlays would be realized as a result of non-service-connected veterans with family incomes above this Category B threshold choosing alternative sources for their health care.

The remainder of the FY 1986 savings—$84 million in BA and $76 million in outlays—would come from providing a COLA of 3.1 percent in FY 1986, effective December 1, 1985, in the rates of VA disability compensation paid to service-connected-disabled veterans and disability and indemnity compensation (DIC) paid to the survivors of those who have died from service-connected causes. As I've indicated already, that is the same percentage increase as the Social Security and VA pension COLA.

Thus, I believe that our two Committees have met our fiscal obligations under the Budget Resolution while continuing with our best efforts to keep the VA—and particularly the VA health-care system—strong and vital so that it can continue to meet the needs of those who answered our country's call in its hours of need.

As I noted when the reconciliation measure was before the Senate last month, this is unquestionably the most important piece of veterans' health-care legislation brought before the Congress since at least 1973, and I believe there is a need to touch on a number of aspects of the legislation incorporated in title XIX of the pending measure.

SUBTITLE A—ENTITLEMENTS AND ELIGIBILITIES FOR HEALTH CARE FROM THE VETERANS' ADMINISTRATION

Mr. President, the greatest differences between the approaches of the two Houses was in the area involving eligibility for VA health care. In discussing the final compromise in this area, I would like briefly to discuss the two approaches, why I believed the Senate's approach in this area was the better course, and how the compromise takes my concerns in this regard into account.

SENATE APPROACH

The Senate-passed provisions modified the eligibility status of two categories of veterans and established some clear, consistent statutory priorities for VA hospitals, outpatient, and nurising home care.

The first category of veterans affected by the Senate legislation consisted of those veterans to whom we have always owed the primary obligation—veterans being treated for their service-connected conditions and also those veterans with service-connected disabilities rated at 50 percent or more disabling. Veterans in this latter

category have been given special recognition by the Congress since 1976 when they were accorded eligibility for unlimited outpatient care and were given a top priority for receiving that care ahead of all but veterans seeking care for their service-connected disabilities. These two groups of veterans would have been given a comprehensive entitlement to VA care, including both hospital and outpatient care as well as, in some instances, contract services where necessary.

Those veterans in this category needing nursing home care for their service-connected disabilities would also have been entitled to that care at VA expense.

The second category of veterans directly affected by the Senate leigslation would have been those non-service-connected veterans age 65 and older who had family incomes over $25,000 in the preceding calendar year. Veterans in this category would no longer have been automatically eligible for VA care without reference to their ability to pay for that care. Rather, they, as well as non-service-connected veterans under the age of 65 with such family incomes, would have still been eligible to receive VA care but would have had to make a modest payment to the VA for it. The eligibility of this latter category of veterans under the Senate legislation would have been expressly conditioned on there being space and resources otherwise available for their care.

For veterans presently eligible for VA care who were in neither of these categories, eligibility for VA care would have remained essentially unchanged; the VA would have been authorized to furnish them with such care to the extent of available VA resources and facilities. However, a new, objective standard of eligibility based on income for non-service-connected veterans would have been established.

In connection with the veterans' health care generally, the amount of health care that can be furnished by the VA is a function of the level of funds appropriated for that purpose by the Congress. All such funds must, under the Budget Act, be made available to be spent for such purposes. Thus, the eligibility of veterans—other than those in the new entitlement categories because of their contract care entitlements as well—for care under the Senate approach would have depended on the outcome of the appropriations process, an area where those of us with a strong interest in the VA health-care system have enjoyed considerable success in the past.

In fact, during my 17 years in the Senate, during which time I have been either the chairman—for 12 years—or the ranking minority member, for the last 5—of the subcommittee or full Committee with jurisdiction over the VA health-care system, I have been deeply involved in an ongoing effort to equip the VA to provide first-quality, modern medical care to veterans. Over that period, we have, through the appropriations process, added 66,000 health-care workers to the VA system. Although the vast bulk of that increase occurred in the 1970's, we have continued with our efforts in support of the system. Just this October, Chairman Murkowski and I, in connection with the VA's fiscal year 1986 appropriation, managed to restore $100 million to the medical care account. However,

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in this time of budget deficits it is very difficult to predict the future success of such efforts.

Thus, the Senate measure provided generally for a three-level approach—entitlement for care for the principal beneficiaries of the VA system, maintenance of current eligibility generally for all other veterans presently eligible for VA care except those non-service-connected veterans with family incomes above $25,000 for the preceding calendar year, and eligibility for care for those in that last group if space and resources are otherwise available and certain payments are made by the veteran. I believe that this struck an appropriate balance and represented, in the last analysis, a promise we in the Congress could reasonably strive to realize in the current time of fiscal restraint.

Together with the statutory priorities proposed in the Senate measure—with the first priority being accorded to service-connected veterans receiving care for their service-connected conditions—that approach should have ensured that the VA health-care system would continue, in its present configuration, to meet its principal mission of providing needed health care to service-connected veterans and other veterans made eligible for such care.

HOUSE APPROACH

In contrast, the approach taken in the House bill did not seem reasonable to me. The apparent purpose of the House approach was to create an entitlement to hospital and outpatient care for all veterans presently eligible for VA care except for non-service-connected veterans whose family incomes in the 12 months immediately preceding their application for care are more than three and one-third times the VA pension income standard.

I believe that this approach was flawed in several fundamental ways. First, it appeared to promise an entitlement to VA health care, without limit, for all but one category of veterans—that is, non-service-connected veterans with incomes above certain levels—for example, incomes over $19,659 in the case of veterans with no dependents and family incomes over $25,751 in the case of those with one dependent, with $3,233 more added for each additional dependent. Thus, a married non-service-connected veteran with two children would, under the House bill, have been accorded VA health-care entitlement based on inability to defray the cost of care if his income was not greater than $32,217.

The House Committee has described the effect and intent of its bill in conflicting ways. For example, the Committee Chairman, Representative Montgomery, issued, as Committee Chairman, a press release, dated September 30, 1985, which stated in part:

> By approving the health care provisions of [the House bill], the Committee assured service-connected and needy veterans *for the first time* that, if they need health care from the VA, it will be provided. Period. [Emphasis in original.]

Also, the House Committee report (H. Rept. No. 99-300, 99th Cong. 1st Sess. 773) contained the following statement:

> Under existing law, as well as under the Administration's proposal, an eligible veteran is unable to predict whether care will be available when needed. This uncertainty arises by virtue of the fact that under current law and under the Administrator's proposed means test the Administrator "may" provide care "within the limits of Veterans' Administration facilities." There is no requirement that the Administrator do so. In contrast, the Committee bill would require VA to provide health care to several categories of veterans.

In contrast, the Committee report contained this statement of caution and limitation about the effect and content of the House bill:

> The bill would require the Department of Medicine and Surgery of the VA to plan to care for all eligible veterans under a new section 610 of title 38, United States Code. The care would be provided in the VA facility where the veteran applied for admission, or another VA medical facility within a reasonable distance.

But, this language was nowhere brought out in the House debate during consideration of the reconcilation legislation. (Congressional Record, October 23, 1985, H9028-H9029.)

So, most veterans would clearly have been led to believe by press reports and other information they received that they were being guaranteed VA care by the House legislation.

In contrast, I do not believe that we in Congress can today, in good conscience, purport to be guaranteeing the VA's ability to furnish inpatient and outpatient care to all those to whom the House bill would have seemed to extend entitlement to care. And, it seems even more clear that the VA will be unable to furnish the amounts of hospital care—let alone outpatient care which is oversubscribed now—seemingly promised by the House bill in either the near- or long-term future if any of the projections prove true regarding the anticipated increase in demand for VA care that will come in the 1990's from the growing population of older veterans.

The ability of the VA system to provide care is, as I noted a moment ago, a function of the level of appropriations made for VA medical care. The House proposal, by its terms, could not control the outcome of the appropriations process. Its purpose would seem to have been to influence that process.

I believe, however, that it would be very unwise for Congress to suggest to all of the veterans to whom the House bill would seem to have extended entitlement that, as a result of the House-proposed legislation alone, the VA health care system would be there for them, now and in the future, whenever they may seek care. Without providing the funds—both to operate the current system with such additional staff and resources as might be needed and to repair, renovate, and modernize existing facilities, as well as to construct new facilities in those areas of the country with the greatest potential for new demand—such a result cannot be guaranteed.

I also believe the House approach was flawed to the degree that it was based on a belief that substantial increases in funding for the VA system will be forthcoming in the near future. In this time of skyrocketing federal deficits and harsh budget realities, made more intense by the Gramm-Rudman deficit reduction legislation that was enacted last week, we will have to do everything in our collective power in our two Committees just to hold onto the present VA system—just to maintain its current capacities. We cannot realistically be suggesting to America's veterans that there is room for the creation of broad new entitlements for care in a system that will almost certainly be faced with reductions in the next few years and which may well be forced by the deficit reduction process now in law to reduce its personnel by more than 5 percent over the next 3 years and possibly much more thereafter.

Another factor which highlights the flawed nature of the House approach is the lack of any mechanism in the House legislation or under current law—such as review in court—by which a veteran might seek to enforce his or her new entitlement to care. In light of the bar in section 211(a) of title 38 to court review of claims for VA benefits—a bar I am certain would apply in the case of a veteran contesting a denial of health care—the "promise" of the House approach would be unenforceable and, for the veteran denied care, empty. In this regard, it is ironic to note that the purported establishment of this "right" without "remedy" was quite deliberate. The Senate has four times passed judicial review legislation to remove this section 211(a) bar, S. 367 on July 30, 1985, S. 636 on June 15, 1983, S. 359 on September 14, 1982, and S. 330, on September 17, 1979. In the case of the first three bills the other body refused to take up that legislation just as it has with respect to S. 367 for this first session of the Ninety-Ninth Congress up to this point.

Mr. President, although the compromise agreement follows in many respects the House approach in the area of entitlement and eligibility for care, it was modified in a number of important ways in response to the concerns I have just outlined.

CONFERENCE APPROACH ON HEALTH CARE ELIGIBILITY

First, and most importantly, although the word "shall", rather than "may" as in current law, is used in describing the eligibility for hospital care of various categories of veterans—largely derived from the House bill—the meaning of that change in eligibility is spelled out specifically, definitively, and unambiguously by both Committees in the Joint Explanatory Statement accompanying the Conference report.

In that statement, the conferees have set forth their intention regarding those veterans as to whom the Administrator "shall furnish" hospital care—any veteran for a service-connected disability; a veteran with a service-connected disability rated at 50 percent or more; a veteran with a service-connected disability rated at less than 50 percent (including a veteran discharged for a disability incurred or aggravated in the line of duty and a veteran disabled as a result of VA treatment or vocational rehabilitation); a veteran who is a former prisoner of war; Vietnam veterans exposed to certain toxic substances or veterans exposed to radiation from nuclear

detonations; veterans of the Spanish American War, Mexican Border period, or World War I; and veterans who are Medicaid-eligible or in receipt of chapter 15 improved VA pension and those whose family incomes are no greater than the new, first level income threshold, the $15-$18,000 Category A threshold. As to those veterans, the conferees have stated definitively and emphatically that "the VA's sole obligation", if such a veteran is in immediate need of hospitalization, is "to furnish an appropriate bed at the VA facility where the veteran applies for care" or, if no bed is available at the VA facility, "to furnish a contract bed (as authorized under current law as recodified in new section 603) or to arrange to admit the veteran to the nearest VA medical center (VAMC), or Department of Defense facility with which the VA has a sharing agreement, with an available bed." If the veteran in one of these "shall furnish" categories who is seeking care is not in need of immediate hospitalization, the VA's obligation would be either to "schedule the veteran for admission where the veteran applied, if the schedule there permits", or if it does not, to "refer the veteran to the nearest VA facility, or DOD facility with which the VA has a sharing agreement, with an availabe bed and to facilitate the veteran's admission."

Thus, Mr. President, the apparent promise of the House bill of an unlimited entitlement to both hospital and outpatient care for a wide range of categories of veterans, including those with no service-connected disabilities and with incomes of up to more than $25,000 for a veteran with one dependent—a promise which, as I indicated earlier, I do not believe can be kept—has been recast into a far more achievable pledge with respect to hospital care only.

Entitlement of veterans meeting "Category A" income threshold

The other major changes that have been made to the House proposal in this area to make it more workable are, first, a lowering of the income levels for those non-service-connected veterans who would be given this form of "entitlement" to care—from levels of approximately $20,000 for a veteran with no dependents and $25,000 for a veteran with one dependent in the House bill, to levels of $15,000 and $18,000, respectively, with $1,000 for each dependent; and second, limiting this new form of entitlement to hospital care only, rather than to hospital and outpatient care as was provided in the House bill. This latter change was necessary because it is already clear, in many areas of the country, that the VA is unable to meet the existing demand for outpatient care. There is simply no basis for suggesting that there will be resources available to the VA to furnish outpatient care to the categories of veterans that the House sought to entitle to such outpatient care.

Veterans age 65 and older

As in both the Senate and House bills, the conference agreement would provide for a change in the eligibility for VA care of non-service-connected-disabled veterans age 65 and older who have family incomes over a certain level. Under the compromise agreement, these veterans with annual incomes—for the preceding calendar year, as in the Senate bill—of over $20,000 for veterans with no dependents, and over $25,000 of family income for those with

one dependent, would no longer be automatically eligible for VA care without reference to their incomes. Rather, they, along with non-service-connected-disabled veterans under age 65 with incomes over these levels, would be required to make a modest payment to the VA—in an amount generally comparable to a corresponding deductible or copayment requirement under Medicare—in order to receive VA care. As was provided for in the Senate bill, the eligibility of these veterans with incomes above this new Category B income threshold would be expressly conditioned on there being space and resources otherwise available at the VA facility where they seek care.

Another provision relating to these veterans age 65 and over which was included in the Senate bill would have established a priority for care for veterans in this age group with incomes above the $20,000/$25,000 level ahead of veterans below that age with such incomes. Unfortunately, our House colleagues would not accept that provision and it is not included in the final agreement.

Intermediate category of eligibility

The conference agreement would establish a third, intermediate category of veterans eligible for VA care in addition to the two categories that I have already described—those two being veterans with incomes no greater than the Category A threshold who would be "entitled" to VA hospital care, and veterans with incomes above the Category B threshold who would be eligible for VA care upon agreeing to make a payment to the VA in connection with their care. This new, third category would consist of those veterans with annual incomes at or above the Category A, but not greater than the Category B, thresholds—for a single veteran, an income above $15,000 but no greater than $20,000 and, for a veteran with one dependent, an annual family income above $18,000 but no greater than $25,000, with $1,000 added for each additional dependent. The Administrator would be authorized to provide care to these veterans within available VA resources and facilities. These veterans would make no payments in connection with their care.

Determining income under new thresholds

In determining a veteran's income for the purposes of eligibility under the two new income eligibility criteria thresholds—Category A and Category B—the Administrator would be required to determine a veteran's annual income—taking into account family income and other assets—generally using the same methods and criteria used to determine annual income for the purposes of VA chapter 15 improved pension eligibility. This income eligibility determination would be made upon a veteran's first application for care each year on a form including income questions similar to those used for determining VA pension eligibility and would be based on the veteran's family income for the calendar year immediately preceding the application for care. Such a determination would then be applicable for the balance of the calendar year.

As I noted a moment ago, if a veteran were eligible for care only by virtue of agreeing to make a payment to the VA in connection with the needed care, the payment required would be in an amount generally comparable to a corresponding deductible for hospital

care—$492 beginning in 1986—or copayment requirement for outpatient care—20 percent—under Medicare. However, the payments required under the conference agreement would be substantially less than the required payments under Medicare for episodes of inpatient hospital care beyond 60 days.

Under the conference agreement, the payment schedule would be as follows:

Hospital care: During any 365-day period (1) for the first 90 days of care (or part thereof), the lesser of the cost of furnishing the care or the amount of the inpatient Medicare deductible in effect at the beginning of the 365-day period, and (2) for each succeeding 90 days of care (or part thereof), the lesser of the cost of furnishing the care or one-half of the amount of that inpatient Medicare deductible.

Nursing home care: During any 365-day period, for each 90 days of care, the lesser of the cost of furnishing the care or the amount of the inpatient Medicare deductible.

Outpatient treatment: For each outpatient or home health visit, the amount equal to 20 percent of the estimated average cost of an outpatient visit to a VA facility during the fiscal year in which the treatment is furnished, but not to exceed during any 90-day period the amount of the inpatient Medicare deductible in effect at the beginning of that period.

Combination of hospital and nursing home care: In the case of a veteran who pays the inpatient-Medicare-deductible amount in connection with VA-furnished hospital or nursing home care and who, before using 90 days of the initial mode of care (hospital or nursing home) within a 365-day period, is furnished the other mode of care, the veteran would not be required to make any payment for the second mode until either (1) the number of days of hospital and nursing home care combined exceed 90, or (2) the beginning of the next 365-day period, whichever occurs first. If the veteran pays an amount equal to one-half of the inpatient-Medicare-deductible amount in connection with receiving hospital care (as when the veteran is receiving more than 90 days of hospital care in a 365-day period) and, before using the 90 days of hospital care for which that payment was made within the applicable 365-day period, receives VA-furnished nursing home care, the veteran would be required to pay one-half of the deductible amount in connection with the number of days of nursing home care that, when added to the hospital days, do not exceed 90 within that 365-day period.

Payments for combinations of outpatient treatment and hospital and nursing home care: A veteran would not be required to pay an amount greater than the inpatient Medicare deductible in connection with any combination of outpatient and inpatient care furnished during any 90-day period.

TWO SENATE PROPOSALS NOT IN CONFERENCE AGREEMENT

Mr. President, although I am generally satisfied with the conference agreement that we worked out with the House conferees as it relates to health-care eligibility and entitlement, there were two

proposed changes in the law from the Senate bill as to which I regret we were unable to gain the House conferees' agreement.

Certain service-connected outpatient and contract-care entitlements

The first of these provisions would have established a clear, comprehensive entitlement to outpatient, as well as hospital, care for veterans for their service-connected disabilities and for veterans with service-connected disabilities rated at 50 percent or greater and entitlement to contract outpatient care for both categories and to contract hospital care to veterans for their service-connected disabilities. I have long believed that these categories of veterans are and should be the principal beneficiaries of the VA health-care system and, as such, deserve the entitlement to care and the statutory priority for receiving that care that the Senate bill would have provided.

As I noted, however—and I must confess my surprise at this result, even though the House bill would have achieved the same result for these two categories of veterans in terms of direct VA care—we were unable to secure the support of the House conferees for this result. As a consequence, these two categories of veterans are included along with the other categories of veterans as being given the form of limited "entitlement" that I described as being in the conference agreement.

Special obligation to veterans with 50-percent or more service-connected disabilities

Nevertheless, I am pleased to note that the conference agreement does contain provisions I strongly urged to emphasize our special obligation to those veterans with service-connected disabilities rated at 50 percent or more. Specifically, these veterans are included expressly in a separate category for the "entitlement" to hospital care in revised section 610(a)(1)(D) of title 38—the first time that they have been given this separate recognition in the context of hospital care—and are accorded outpatient care eligibility in the provision, revised section 612(a), together with veterans being treated for their service-connected conditions rather than in section 612(f), as in current law, with veterans receiving care for their non-service-connected disabilities. Their placement in section 612(a) will provide these 50-percent-or-more disabled veterans with eligibility for structural alterations to their residences, in connection with the provision of home health services where necessary to enable the veteran to live at home, costing up to $2,500 as opposed to the $600 limit applied to non-service-connected veterans generally under current section 612(f) and revised section 612(f)(2).

It is my strong hope that the heightened recognition being accorded to this category of veterans in the conference agreement will be reflected in VA practices and procedures, including establishing in VA regulations a priority—which current regulations, 38 C.F.R. 17.49, do not contain—for these veterans when they seek hospital care.

Statutory priorities for care

The second issue as to which I regret the outcome in the conference agreement involves the establishment of statutory priorities

for VA care. The Senate bill would have added a new section 612C to title 38, United States Code, to require the Administrator to establish statutory priorities for furnishing hospital, domiciliary, and nursing home care as well as, under current law in section 612(i), medical services. The Senate bill would also have required the Administrator to prescribe regulations to ensure the provision of care and services in that priority order.

Except in cases of a medical emergency, the priorities for hospital, domiciliary, and outpatient care would have been set forth, with the first two categories being as they currently are for outpatient care: First, veterans who require treatment for service-connected disabilities and, second, veterans with service-connected disabilities rated at 50 percent or more.

Establishing these priorities as proposed in the Senate bill would have constituted an expression of congressional policy as to which veterans should receive care in situations in which there may be a scarcity of resources, situations that may well be occurring with increasing frequency beginning by the end of the decade. Unfortunately, the only change to current law that the House conferees were willing to accept involved accepting my proposal to add one additional category of veterans—those in receipt of improved VA pension under section 521 of title 38—to the existing priority listing for outpatient care in section 612(i) of title 38.

Although this is far less than I wanted or believed appropriate in terms of statutory priorities for care, it is an important result in ensuring that truly needy war-time veterans in receipt of VA pension—those, for example, with incomes of no more than $5,885 for a veteran with no dependents and with family incomes of $7,709 for a veteran with one dependent—will be given a priority for outpatient care ahead of other non-service-connected veterans with higher incomes. With further reference to veterans in receipt of pension, I note that they, as well as veterans in receipt of Medicaid, would be automatically placed in Category A in terms of their eligibility for VA care and need not complete any separate income form to establish this eligibility.

Contrast with the Administration-proposed legislation

Mr. President, the conferees' final agreement regarding health-care eligibility issues can perhaps be best understood in contrast to the legislation that the Administration first proposed in connection with the fiscal year 1986 budget and submitted formally in late April.

That proposal involved an $11,400 income cutoff for a single veteran and generally provided no opportunity for such a veteran above that income level to become eligible for VA care except by "spending down" major portions of his or her income above the cutoff line and then, each time—I repeat, each time—VA health care was sought, demonstrating to the VA that such expenditures had in fact been made. That approach could well have resulted in the VA turning away sick veterans who actually would have been unable to afford the care they needed and who would be cared for by the VA under current law.

The effect of that proposal would have been that each non-service-connected veteran seeking care on the basis of being unable

to defray the cost of care would have been required to establish and then reestablish income eligibility each time he or she applied for care. Indeed, the House bill would have required similarly that veterans reestablish eligibility each time they applied for care. The Administration's proposal would have been both individually demeaning and extraordinarily burdensome for the veteran seeking to qualify for eligibility on the basis of income—including many very elderly veterans—and administratively costly and difficult for the VA.

That is why I announced this past Spring when the Administration plan first surfaced that I categorically rejected that kind of administratively complicated and burdensome and generally debasing approach, and I am pleased to say that the legislation developed by the conferees bears no resemblance to that Administration proposal.

The approach we are proposing in the conference agreement thus must be viewed against the backdrop of knowing that the administration has existing authority to establish a means test and that, should Congress take no action, the VA would certainly do so along the lines of the totally unacceptable proposal that the VA has previously made.

Technical matters

Finally, as I did when this legislation was before the Senate last month, I want to touch briefly on some technical matters regarding the changes relating to VA health-care eligibility proposed in this subtitle.

Contract-care eligibility

The first such point relates to a proposed change in the wording of the title 38 sections setting forth eligibility criteria with respect to hospital care, nursing home care, and outpatient treatment. Those sections currently provide eligibility for care "within the limits of Veterans' Administration facilities", which is defined to include both the VA's own facilities and certain other Government facilities as well as private facilities with which the VA may contract for hospital and outpatient care in the circumstances specified in current section 601(4)(C) of title 38. The contract authority for nursing home care is in section 620.

The Senate bill would have replaced the phrase "within the limits of Veterans' Administration facilities" with the phrase "through Veterans' Administration facilities or through non-Veterans' Administration facilities to the extent authorized in section 603 of this title" and would have reenacted the contract-care eligibility in a new section 603, taking it out of its current-law location as part of the definition—quite anomalously—of "Veterans' Administration facilities" in present section 601(4)(C), thus providing a more direct reference to the VA's contract authority. The conference agreement generally incorporates this approach with a redrafting and relocation—for example, to sections 610(a)(3), 612(a)(3), and 612(f)(3)—of the reference. The use of the new terminology—and the shifting to a new section 603 of the provisions in current law section 601(4)(C) specifying the circumstances under which contract care may be furnished—are not intended to change the effect

of current law but rather to achieve greater clarity on the face of the statute regarding the extent of eligibility for contract care—often referred to as "fee-basis" care.

This new drafting formulation is also intended to make clear—as is the drafting, in revised section 610(a)(3) relating to nursing home care, by the use of the phrase "or as provided in section 620 of this title"—that the extent to which any fee-basis authority is provided is determined solely by what is in section 603, or section 620 as to nursing home care, in conjunction with other provisions of chapter 17, and that the Administrator's general authority to contract under current section 213 is not available with respect to any of these chapter 17 health-care authorities. As was pointed out in our Committee's report language (S. Rept. No. 99-146, 99th Cong., 1st Sess. 591-92), the Committee construes the words "within the limits" used in current law as providing the same limitation as to the nonavailability of section 213, but believes that the new formulation is more definitive and clearer in this regard.

Emergency care

A second technical point that I want to note regarding the provisions relating to revisions in VA health-care eligibility involves the relationship between the new requirement that some veterans have to agree to make payments in connection with their care, on the one hand, and the VA's existing authority to provide care in emergency situations, on the other. Although a veteran with annual family income above the Category B income threshold would generally be eligible for care or services only upon the veteran—or someone authorized to act for him or her—agreeing to pay for those services before they are provided, the VA has full authority under current section 611(b) to furnish hospital care or medical services in emergency cases and to charge the veteran for the approximate amount of the VA's costs for furnishing such care. This emergency authority would be applicable in the case of a veteran in this new category of eligibility who for any reason is unable to execute such an agreement prior to the commencement of care, thereby permitting the VA to furnish whatever care is necessary in an emergency situation and thereafter, as appropriate, to charge the veteran for such care in accordance with the new payment amounts specified in the law to be paid in connection with being furnised VA care.

RECOVERY OF THE COST OF CERTAIN HEALTH CARE AND SERVICES FURNISHED BY THE VA

Mr. President, turning to the second major element in subtitle A of the legislation in title XIX—the section which would provide for the VA to recover from third-party health insurers for the cost of care provided to insured non-service-connected-disabled veterans—these provisions generally follow the Senate approach. As I noted in my remarks last month, my position on such legislation has been clear for many years, dating back to 1979. I believe that such legislation does not make any sense from the standpoint of sound public policy.

It is clear beyond any question that the enactment of this legislation will not reduce the overall cost of VA health care; in fact, the

opposite is true because this legislation would have an inflationary impact. This is so both because each unit of health care provided by the VA for which third-party recovery is sought would now have two additional administrative components attached—each paid for by taxpayers ultimately—and because the third parties' costs of processing and responding to the claims would be passed on to those who pay health-insurance premiums as well as taxes.

It is also clear to me that the legislation constitutes a totally unwarranted Federal Government intrusion into private contractual relationships by rewriting some of the most basic terms and conditions of marketplace commercial insurance agreements.

In this regard, I refer my colleagues and others with an interest in this legislation to the excerpts I read into the Record last month from a letter written by Bernard Tresnowski, the President of the Blue Cross and Blue Shield Association, in response to a Washington Post editorial on VA third-party reimbursement legislation. As I noted then, this letter—the excerpts of which begin on page S15471 of the Record for November 14—is about as succinct an analysis as I've ever seen of the problems with such legislation.

Mr. President, the point that I believe is so well founded that is raised against this legislation—that it violates fundamental principles of insurance—could not be made more clear than by reading revised section 629(a)(3)(A) of title 38 in the conference agreement. This provison would permit the VA to collect under an insurance contract even where the policy is expressly contingent on the insured having satisfied a deductible or paid a copayment and the insured veteran has not satisfied those requirements. Plainly and simply, this provision proposes to rewrite insurance contracts to give the VA a right to collect in situations in which other health-care entities could not. Equally as clearly, without this provision, this third-party reimbursement legislation would not work at all as to most health insurance plans.

But the savings estimate attached to this legislation and the opportunity to point a finger at someone else, the health insurance companies, and say that they are not bearing their fair share of costs made this approach irresistible. On this latter score, as I have pointed out repeatedly, no one has been able to demonstrate to my satisfaction that insurance companies have received any windfall from the exclusionary clauses. Rather, these clauses reflect standard, sound insurance theory and practice.

However, our two Committees were faced with very significant reconciliation instructions, and our being credited by CBO for savings, through third-party recoveries, of $960 million over three years—a hopelessly optimistic projection, I might add—through the enactment of such legislation made this an option our Committees "simply could not refuse".

In view of the inevitability of the enactment of some kind of legislation in this area, I did my best to attempt to help craft it in such a way as to make it as workable and as fair as possible. In this effort, I consulted closely with the VA, representatives of various third-party insurers, and others with an interest in the legislation.

I would like to highlight two very significant points that are appropriately addressed in the conference agreement.

VA compliance with contract terms

First, the language providing for the right of recovery of the cost of care "to the extent" that the veteran or a non-Federal provider would be eligible to receive payment generally leaves the Federal Government's right to recover contingent upon compliance with the terms and conditions of the law, contract, or other arrangement under which the veteran would be eligible for payment by the third party. Only where the proposed legislation specifically overrides such terms or conditions—the provision in the legislation nullifying preclusions of liability for VA care and the provision I have just cited providing for recovery despite a deductible or copayment not being met—would such requirements be voided. Thus, contract requirements conditioning the third-party's liability—such as for pre-hospitalization screening for second opinions prior to surgery or other specified utilization review procedures—would apply. Likewise, provisions imposing general limitations on the third-party's liability—such as contract clauses placing specific dollar limits on payments for certain procedures, limiting a carrier's liability to a percentage of certain charges, or, as in the case of health maintenance organizations, limiting coverage to care provided in specific facilities—would apply. Our Committee report language—as printed on pages 577 and 578 and pages 627 and 628 of S. Rep. No. 99-146—makes these points clear.

Depositing collections in miscellaneous receipts

Second, VA health-care appropriations are not to be reduced in anticipation of collections. Rather, revenues received will be remitted directly to the Treasury to reduce the deficit. Without this provision, which was contained in prior Administration's legislative proposals, I could and would have never agreed to this legislation since deposit of the collected revenues in the VA medical care account would lead to reductions in that appropriation being made up front based on anticipated revenues. The effect of this approach would be to hold the system hostage for a result it could in no way guarantee—that insurers would agree to these payments and that the payments would be forthcoming at certain levels, both fairly readily and expeditiously. Indeed, there continue to be significant questions in my mind as to whether any appreciable revenue will be produced by these third-party provisions for several years after enactment, if even that early.

SUBTITLE B—DISABILITY COMPENSATION COST-OF-LIVING ADJUSTMENTS

[NOTE.—The disability compensation provisions were deleted in the final version.]

SUBTITLE C—MISCELLANEOUS PROVISIONS

["Subtitle B" in the final version.]

Epidemiological study of female Vietnam veterans

Mr. President, section 19021 of the conference agreement contains a provision that would require the Administrator, unless determined not to be scientifically feasible to do so, to provide for the

conduct of an epidemiological study of the health of women Vietnam veterans—a so-called "Vietnam-experience" study. This section was derived from a provision in the House bill and from a Senate provision in section 507 of S. 1887, the "Veterans' Compensation and Benefits Improvements Act of 1985". The Senate provision was derived from one that I first introduced in S. 1616, to require a study of any long-term adverse gender-specific health effects in female Vietnam veterans that may result from their exposure to Agent Orange or to other phenoxy herbicides and to authorize the Administrator to expand the scope of the study to include a so-called "Vietnam-experience" study evaluating any long-term adverse gender-specific health effects in females resulting from any aspect of service in Vietnam.

Mr. President, at the time I introduced S. 1616 and at the time of Senate passage of S. 1887, I discussed the need for such study in detail. I refer my colleagues to my remarks in the Congressional Record of September 10, 1985, S11201-04, and of December 2, 1985, S16630-31.

The Centers for Disease Control is currently conducting a large study designed to learn about the health status of Vietnam veterans in general. That study includes three major research components: An Agent Orange Study, a Vietnam-Experience Study, and a Selected Cancers Study. Although it is expected that a significant level of information regarding health issues for Vietnam veterans in general will result from this effort, the CDC-conducted study will not provide any information about the unique experiences and gender-specific concerns of women Vietnam veterans.

For this reason, since early 1984, I have been urging, along with other members of the Veterans' Affairs Committees, that the Executive Branch utilize existing authorities to design and undertake an appropriate study of women Vietnam veterans. I am pleased that this provision has been included in the pending legislation, and look forward to having this long-overdue study of the general and specific health status of women Vietnam veterans scientifically reviewed. If not scientifically infeasible to do so, study of health effects that may have resulted from specific factors in service—such as exposure to Agent Orange or other toxic substances, or traumatic experiences—would also be authorized, although not required by this provision in the conference agreement.

Advisory Committee on Native-American Veterans

Mr. President, I also want to make special mention of the provisions of the conference agreement—in section 19032—that would establish within the VA an Advisory Committee on Native-American Veterans. These provisions are derived from the provisions of section 505 of S. 1887 as it was passed by the Senate on December 2 as well as from the provisions of section 1981 of the House Bill.

Native Americans have a long and distinguished record of service in the Armed Forces of the United States. Their service and subsequent readjustment, in many cases, has taken place in the context of cultural and economic conditions different from those of many other veterans. Yet no evaluation of the particular needs of Native-American veterans has ever been undertaken by the VA. I believe that the differences between Native-American veterans and

their non-native veteran counterparts and the diversity within the Native-American veteran population itself merit an in-depth evaluation to identify situations or needs unique to Native-American veterans and to assess the effectiveness of VA programs and services designed to meet those needs. This Advisory Committee will be charged with such an evaluation and with the responsibility of making two reports to the Administrator—on November 1, 1986, and November 1, 1987—on the Committee's findings and recommendations. The Administrator, in turn, would be required to present those reports to the Congress, together with his findings and recommendations for administrative or legislative action.

Mr. President, as the Senator from the State where more Native-American veterans reside than in any other State—over 27,100 American Indians reside in California, nearly 17 percent of the total U.S. Native-American veteran population—and having initiated the provision in the Senate legislation for the evaluation to be carried out by an Advisory Committee with Native-American veteran representation on it, I pressed for inclusion of this provision in the conference agreement. I look forward to receiving and reviewing with great interest the results of the Advisory Committee's evaluation.

Waiver of waiting period for administrative reorganization of certain VA automated data processing activities

Mr. President, section 19033 of the conference agreement contains a provision that would waive, with respect to a particular proposed VA reorganization, the waiting period prescribed by section 210(b)(2) of title 38—which provides, in part, that the VA may not in any fiscal year implement certain administrative reorganizations unless the Administrator, not later than the date on which the President submits the budget for that year, provides a report containing a detailed plan and justification for the reorganization. The particular reorganization involves the transfer of certain functions from the VA's Office of Data Management and Telecommunications to the VA's Department of Veterans' Benefits.

Mr. President, as many Senators may know, on February 1 of this year, the Administrator submitted to the Committee letters giving notice of the VA's decision to close down a wide range of VA activities at its 59 DVB regional offices and to consolidate those activities in 3 processing centers. The Administrator stated that his letters were submitted in accordance with section 210(b)(2).

Mr. President, that proposal and the lack of detail in the February 1 letter raised questions—many of which still remain unanswered—regarding the impact of the consolidation on the furnishing of various types of benefits and services to veterans and their dependents as well as on the employees affected. The opinion was thereafter expressed in both the Senate and the House—by myself and the Chairman and Ranking Minority Member of the House Committee on Veterans' Affairs—that the February letter was so lacking in detail as not to constitute a valid section 210(b)(2) "detailed plan and justification". In an undated opinion addressing this issue, the Acting General Counsel of the VA declined to state whether it did or did not.

In order to resolve the question of what specifically constituted a "detailed plan and justification", I introduced on June 27, joined by Senators Matsunaga, DeConcini, and Rockefeller, S. 1397, the proposed "Veterans' Administration Reorganization Act of 1985". This legislation set forth a definition of precisely what type of information a detailed plan and justification for a proposed reorganization must contain under section 210(b)(2). Provisions derived from this measure were incorporated into section 501 of S. 1887 as reported from the Committee and were approved by the Senate on December 2.

Thus, Mr. President, despite the fact that those provisions have not yet been enacted into law and the fact that the proposed reorganization involving DVB and ODM&T in no way relates to the poorly-conceived and ill-advised proposal to consolidate regional office, I believed it was appropriate and necessary that the proposed DVB and ODM&T reorganization be supported by the kind of detailed plan and justification that section 501 of S. 1887 would expressly require, and I so notified the Administrator in a December 6 letter to him.

It was in that context that I considered and examined the Administrator's letter. So that members can also have an opportunity to understand this proposal, I ask unanimous consent that the texts of his December 4 letter to me which is identical to the November 1 letter and of my December 6 letter to him, together with the provisions of section 501 of S. 1887, be printed in the record at this point.

[There being no objection, the material was ordered to be printed in the record, as follows:]

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

RECD

DEC 4 1985

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D. C. 20510

Dear Senator Cranston:

The purpose of this letter is to report a planned administrative reorganization within the Veterans Administration (VA) involving the transfer of certain functions from the Office of Data Management and Telecommunications (ODM&T) to the Department of Veterans Benefits (DVB).

As you are aware, under the Congressional "report and wait" requirements of 38 U.S.C. § 210(b)(2), a detailed plan and justification must be submitted to the appropriate committees of Congress for certain VA administrative reorganizations involving a reduction during any fiscal year by 10 percent or more in the number of full time equivalent employees (FTEE) at a VA covered office or facility. The report must be made not later than the date on which the President submits his budget for the next fiscal year. Thereafter, no action can be taken to implement the reorganization until the first day of that fiscal year. This letter is submitted in order to satisfy the above-reporting requirement for a planned VA organizational transfer of certain automated data processing (ADP) functions as described below.

As you are aware, in April 1985, the Veterans Administration selected McManis Associates, Inc., to prepare an implementation plan to modernize the DVB benefits and services delivery systems. This plan was to be consistent with my policy statement mandating the full modernization of the Agency's data processing and communications systems so as to improve the quality of service provided to veterans and their families. The McManis study among other things found that there was limited end-user involvement in system design and development, limited systems training, and that there were inconsistent system utilization management practices. Based on these findings, I approved the McManis recommendations that DVB should have the authority, resources and responsibility for the systems development and greater operational oversight

within overall agency standards and policy guidelines. Implementation of this recommendation requires the administrative reorganization which is the subject of this letter.

We propose to reorganize in order to move ADP program specialists closer to the DVB program specialists, and give DVB a greater role in ADP decisions. By giving DVB control of ADP resources, they will be able to better focus ADP expenditures on service delivery priorities. This reorganization will involve 362 ODM&T full time equivalent employees (FTEE). These organizational transfers will occur at VA Central Office (VACO), and at the Austin, Texas; Hines, Illinois; and Philadelphia, Pennsylvania VA Data Processing Centers (DPC). The number of FTEE transferred as the result of this reorganization and the base 1986 ODM&T FTEE at each facility, are as follows: VACO--81/441; Austin--75/663; Hines--146/406; and Philadelphia--60/197.

The functions performed in the positions to be transferred are unique to the support of DVB programs and, after this transfer to DVB, ODM&T will no longer perform these functions. These functions, and the stations at which they are performed, are as follows: VACO--Benefits Automation Service, which designs all ADP programming for DVB, and some administrative support personnel; Austin DPC--Benefits Delivery System Division, which does programming for DVB in the areas of loan guaranty, the Beneficiary Identification and Records Location Subsystem (BIRLS), and debt collection (beginning in fiscal year 1986); Hines DPC--System Support Divisions, which handle programming for DVB benefits programs, such as Compensation and Pension, Education, and Vocational Rehabilitation, and which prepare the computer tapes for the Department of Treasury to use in issuing benefits checks; and Philadelphia DPC--Systems Division, which does programming for VA applications. There will also be transferred, at each of the above stations, the functions of that part of the systems verification and testing element which performs systems quality control for the programming done by the benefits delivery system staff at each of these stations.

It is clear from the foregoing that this reorganization is simply an organizational transfer of employees. These employees will not be relocated to other stations. The great majority of them will experience no change in their functions, personnel status, immediate supervision, or even in the location of their workspace. Accordingly, there will be little or no cost impact as the result of this reorganization.

We believe that this reorganization is appropriate and advisable, and that it will have the desired effect of improving and making more efficient DVB benefits delivery systems by giving DVB direct control over the resources used for its ADP support. This reorganization has already been the subject of DVB briefings with staff of the House and Senate Veterans' Affairs Committees. Of course, we would be pleased to provide any additional information which you may desire concerning this reorganization.

I request your assistance in introducing, and supporting enactment of, a legislative waiver of the 38 U.S.C. § 210(b)(2) waiting period for this reorganization, so that these improvements in our organizational structure can be made as soon as possible. Suggested language for such a legislative waiver is enclosed. Absent such a waiver, we must wait until fiscal year 1987 to implement this reorganization.

I appreciate your support for our efforts to improve benefits delivery for our Nation's veterans.

Advice has been received from the Office of Management and Budget that there is no objection to the presentation of this letter and legislative proposal from the standpoint of the Administration's program.

Sincerely,

Everett Rowe Jr.

HARRY N. WALTERS
Administrator

Deputy Administrator • For

Enclosure

FRANK H. MURKOWSKI, ALASKA, CHAIRMAN
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STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

December 6, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

Thank you for your letter of November 1 in which you gave notice of a planned administrative reorganization within the VA involving the transfer of the Office of Construction (OC) to the Department of Medicine and Surgery (DM&S) and in which you request a waiver of the waiting period prescribed by section 210(b)(2) of title 38, United States Code.

As you noted, section 210(b)(2) provides, in part, that the VA may not in any fiscal year implement a reorganization involving a more-than-10-percent reduction in the number of full-time equivalent employees at any VA facility with more than 25 employees unless the Administrator, not later than the date on which the President submits the budget for that year, provides "a report containing a detailed plan and justification for the reorganization."

As you may know, in response, in part, to what I believed was an ill-conceived and potentially damaging plan to consolidate various activities of the Department of Veterans' Benefits 59 regional offices into 3 processing centers, I introduced legislation, S. 1397, the proposed "Veterans' Administration Reorganization Act of 1985", on June 27. A principal thrust of that measure was to define for purposes of section 210(b)(2) precisely what a "detailed plan and justification" for a proposed reorganization must entail.

Provisions derived from this legislation were incorporated into the compensation cost-of-living increase bill that was ordered reported by the Committee on October 31 and passed by the Senate, as S. 1887, on December 2. Specifically, section 501 (copy enclosed) of the bill as passed would define the term "detailed plan and justification" to include at a minimum a number of specific items, including--

(1) a specification of the number and responsibilities of the employees to be added to or removed from each affected office;

(2) a description of the changes in functions that would occur at the affected offices;

(3) an explanation of the reasons why it has been determined that the reorganization is appropriate and advisable in terms of the statutory missions and long-term goals of the Veterans' Administration;

(4) a description of the effects that the reorganization may have on the provision of benefits and services to veterans and dependents of veterans (including the provision of benefits and services through offices and facilities of the VA not directly affected by the reorganization); and

(5) estimates of the implementation cost and the subsequent cost impact of implementing the reorganization.

Although this provision has not yet been enacted, I believe that it likely will be in the near future. In any event, I am not able to support a waiver of the requirement for a waiting period for a section 210(b)-covered reorganization unless the Committee is provided with at least the information that would be required under section 501 of S. 1887 as passed by the Senate. In this regard, I am particularly concerned by your statement, in requesting a waiver in your letter, that "[i]t is uncertain what the organizational change will be on FTEE and costs."

I urge you to provide the Committees with a report containing adequate detail and justification (consistent with section 501 of the Senate-passed bill) in order that we may have all the information necessary to consider meaningfully your request for a waiver of the section 210(b)(1) waiting period.

Finally, with respect to your December 4, 1985, letter reporting a planned reorganization of certain functions from the Office of Data Management and Telecommunications (ODM&T) to the Department of Veterans' Benefits (DVB), I find that letter substantially complete in terms of the information called for by section 501 of S. 1887. There are, however, a few areas that I believe require further clarification under clauses (III), (IV), and (V) of the statutory provision. These items have been called to the attention of Mr. John Vogel, Chief Benefits Director. In order for us to proceed with a legislative waiver for that DVB/ODM&T reorganization, we will need the additional information not later than Wednesday, December 11.

With warm regards,

Cordially,

Alan Cranston
Ranking Minority Member

Enclosure

cc: Honorable Frank H. Murkowski
Honorable G.V. (Sonny) Montgomery
Honorable John Paul Hammerschmidt
Dr. John W. Ditzler
Ms. Susan Livingstone
Mr. R. John Vogel

CLARIFICATION OF REQUIREMENT FOR A DETAILED PLAN AND JUSTIFICATION FOR ADMINISTRATIVE REORGANIZATION

SEC. 501. (a) Subparagraph (C) of section 210(b)(2) is amended by inserting at the end the following new division:

"(iii) The term 'detailed plan and justification' means, with respect to an administrative reorganization, a written report which, at a minimum—

"(I) specifies the number of employees by which each covered office or facility affected is to be reduced, the responsibilities of those employees, and the means by which the reduction is to be accomplished;

"(II) identifies any existing or planned office or facility at which the number of employees is to be increased and specifies the number and responsibilities of the additional employees at each such office or facility;

"(III) describes the changes in the functions carried out at any existing office or facility and the functions to be assigned to an office or facility not in existence on the date that the plan and justification are submitted pursuant to subparagraph (A) of this paragraph;

"(IV) explains the reasons for the determination that the reorganization is appropriate and advisable in terms of the statutory missions and long-term goals of the Veterans' Administration;

"(V) describes the effects that the reorganization may have on the provision of benefits and services to veterans and dependents of veterans (including the provision of benefits and services through offices and facilities of the Veterans' Administration not directly affected by the reorganization); and

"(VI) provides estimates of the costs of the reorganization and of the cost impact of the reorganization, together with analyses supporting those estimates.".

(b)(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall take effect with respect to administrative reorganizations proposed to be carried out in fiscal years beginning after fiscal year 1986.

(2) The amendment made by subsection (a) applies to the administrative reorganization referred to in the letters from the Administrator of Veterans' Affairs to the Committees on Veterans' Affairs of the Senate and the House of Representatives, dated February 1, 1985, relating to the consolidation of certain Veterans' Administration Department of Veterans' Benefits activities from 59 regional offices into three processing centers.

Mr. CRANSTON. Mr. President, the information contained in this letter was subsequently supplemented by information provided by Paul Ising, the VA's Deputy Chief Benefits Director for ADP Systems Management, to the Committee's minority staff on December 9. Clarification was received regarding the statement that "[t]he great majority of them [VA employees] will experience no change in their functions, personnel status, immediate supervision, or even in the location of their workspace." In this regard, I was advised that no individual will experience a change in function or in per-

sonnel status, six individuals will experience a change in immediate supervision, and one individual will move from the second floor to the third floor within the VA's Central Office.

With respect to the reasons for the determination that this reorganization is appropriate and advisable in terms of the statutory missions and long-term goals of the VA, the VA provided the following material extracted from a report prepared by McManis Associates, Inc., which developed and prepared the implementation plan to modernize DVB's service delivery systems:

> In our judgment the Veterans' Administration has little choice but to undertake a major DVB modernization program. Without a major overhaul to its total information management capacity, DVB will not be able to continue to provide an acceptable level of service to veterans and their families. Uncoordinated, overlapping data bases complicate data entry and retrieval. Outmoded hardware, software, and telecommunications technologies are expensive and severely limit data access and analysis capabilities. The existing hardware in the regional offices has reached the point where it must be replaced. Over time, there has been such massive modification to the Compensation and Pension software that maintenance of that system is now enormously costly, and the agency is increasingly at risk in trying to maintain it in its present form. . . .
>
> These recommendations were presented and approved in mid-July and provide the framework within which the modernization program will be carried out. Approval of the recommendations established the parameters to guide the implementation effort: a "modern" architecture should be developed, including appropriate decentralization of DVB systems; and DVB should assume authority and responsibility for its own benefits delivery systems. . . .
>
> We identified two types of organization and management issues which have an impact on the effectiveness and efficiency of DVB service delivery systems. The first type relates to the process by which DVB ADP requirements have been defined and how DVB systems are designed and modified. DVB has had neither direct budget authority nor accountability for its use of ADP resources. It has been dependent upon the Office of Data Management and Telecommunications for all systems development initiatives. End users of the systems have not regularly been involved in the design or acceptance of new applications or modifications to existing applications. There has been no effective mechanism within DVB to establish priorities for systems development or enhancement, nor has there been an effective mechanism to assure ODM&T priorities were consistent with DVB priorities. Without control over the development and support of systems applications, DVB is hampered in its efforts to implement any ADP/telecommunications modernization strategy.
>
> The second set of organizational and management issues identified are internal to DVB. Too rarely have the end

> users in the field offices been involved in the systems design and development process. New automated systems have been introduced and are utilized in the regional offices with limited user orientation and training. The limited involvement of field personnel in systems development has meant that the effectiveness of the system from the perspective of the veteran or the non-technical end-user is often limited.

With respect to providing further clarification for the effects that the reorganization may have on the provision of benefits and services to veterans and dependents of veterans (including the provision of benefits and services through offices and facilities of the VA not directly affected by the reorganization), the VA further cited the McManis report as follows:

> The aim of the proposed modernization effort is to utilize improved technologies on an economically justifiable basis to remove many of the obstacles to improved efficiency and service. With the changes in processing architecture and telecommunications, a number of significant changes in the way regional offices conduct business can be expected:
>
> 1. The veteran will be able to obtain information, resolve problems, and complete processing procedures with fewer stops and by dealing with fewer people.
> 2. Data related to the same event, procedure, or action will be recorded (entered) once. Data transfer to other systems and organizational elements will be effected electronically without the need to reenter or transcribe the data.
> 3. Permanent storage of most correspondence and documentation currently maintained manually on a decentralized basis (Claims Files) will be recorded electronically either in image form or as formatted data.
> 4. All work stations for processing, counseling, testing, and other interactions with the veteran will be supported by multi-function intelligent terminals. Direct concurrent access to the data maintained locally in the RO as well as the very large central data bases located on mainframes will be available at the workstation. This will mean that individuals will be able to perform a variety of procedures without moving from one piece of specialzed computing hardware to another.

In addition, further regarding the relationship of the DVB reorganization to other components of the agency, the VA has advised that the elements of this reorganization are consistent with the three principal strategies of the VA's agency-wide ADP modernization programmatic goals, including eventually providing each authorized VA employee with access to all VA data, regardless of its location in VA computer systems.

Finally, with respect to the cost of the reorganization and its cost impact, the VA has clarified that the only cost of the reorganization is the paperwork involved in processing these changes. It is not expected to be significant, but it is not measurable at this time.

The VA has indicated that there may be some savings in the future in terms of increased productivity but they are long term and, at this point, unestimated.

After careful analysis of the VA's letter, together with the additional information subsequently provided by the VA, I have concluded that the VA had submitted what constitutes a sufficiently detailed plan and justification for this proposed reorganization and that the reorganization will serve to improve the operations of the VA's service and benefits system. However, since, under the provisions of section 210(b)(2), the reorganization would not be permitted to be implemented prior to the beginning of fiscal year 1987 on October 1, 1986, I have supported and the conference agreement includes a statutory waiver of the required waiting period in order to permit the Administrator to implement this reorganization at the earliest possible opportunity.

Finally, I want to express my appreciation to the VA, particularly John Vogel, Chief Benefits Director, and Paul Ising, the VA's Deputy Chief Benefits Director for ADP Systems Management, for their cooperation and assistance in providing the information necessary for the Committees to consider the proposed DVB/ODM&T reorganization and act favorably to permit it to go ahead on an official basis in the near future.

Status of negotiations regarding other veterans' legislation

Before concluding my remarks on this measure, Mr. President, I want to comment on the negotiations between the House and Senate Committees on Veterans' Affairs over the numerous differences between our compensation, education, and other VA benefits measures embodied in S. 1887 and H.R. 1408, H.R. 2343, and H.R. 2344. I regret to note that those negotiations have reached an impasse over certain provisions in the Senate bill—now endorsed by the Administration—designed to improve, and enhance the fiscal stability of, the home-loan guaranty program. As a result of that impasse, it has become clear that further action on the remaining provisions of S. 1887 will not be possible this year.

Mr. President, during the Senate's consideration of S. 1887, I discussed in detail each of these provisions, and my statement on that measure appears at page S16634 of the Congressional Record for December 2 (daily edition). At this time, I want to stress my intention to continue to pursue these matters at the earliest appropriate opportunity in the second session of this Congress and my regret at our failure to be able to reach agreement on this package.

Lastly, with respect to the provisions of S. 1887 as it was passed by the Senate on December 2 that deal with the extension and improvement of the Emergency Veterans' Job Training Act of 1983 [EVJTA] I want to make special mention of the agreement that the distinguished Chairman of the Committee (Mr. Murkowski) and I have reached with respect to these provisions. If we are not able to resolve our differences over the larger legislation early in the next session or to proceed in some other fashion to pass and enact—outside of S. 1887—this EVJTA extension and improvement legislation, Senator Murkowski and I have agreed to return the Senate-passed EVJTA extension legislation to the House in a separate bill by early February.

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SUMMARY OUTLINE

Mr. President, for the information of my colleagues and the public, I ask unanimous consent that a summary outline of the cost-savings provisions of subtitles A and B of the conference agreement be printed in the record at the conclusion of my remarks.

CONCLUSION

Mr. President, as I noted at the outset of my remarks, reaching a final compromise with our colleagues in the House on some of the issues in this legislation—especially those provisions relating to eligibility for VA health care—was a very difficult task. Together, we had a commitment to fulfilling our reconciliation obligations while protecting the VA as much as possible from harm. However, we had very different approaches as to how to reach that shared goal.

In the end, thanks to the efforts of Senators Murkowski and Simpson and Representatives Montgomery and Hammerschmidt and the other conferees—and many long hours of work by staff of both Committees—we were able finally to hammer out the compromise which is before the Senate today and which I recommend to my colleagues.

I want especially to thank the minority staff of the Veterans' Affairs Committee, Bill Brew, Babette Polzer, Ed Scott, Nancy Billica, Ingrid Post, Charlotte Hughes, and Jon Steinberg, for their outstanding efforts on this bill over the last few weeks and months. My gratitude also to the Senate majority staff, Cathy McTighe, Julie Susman, and Tony Principi, for the extraordinary spirit of cooperation and dedication they exhibited in our work together over this very pressurized and trying time period.

I also thank the House staff who worked on this legislation—Pat Ryan, Jack McDonell, Vic Raymond, Arnold Moon, Jill Cochran, Mack Fleming, Rufus Wilson, and Kingston Smith from the House Committee on Veterans' Affairs, and also, Bob Cover, of the House Legislative Counsel's staff who, as usual, worked tirelessly and most effectively in helping to craft the final version of the legislation.

[There being no objection, the summary was ordered to be printed in the record, as follows:]

SUMMARY OF COST-SAVINGS PROVISIONS FROM SUBTITLES A AND B

Hospital care eligibility

A. VA shall in VA facilities, and may in non-VA facilities as authorized in section 603, furnish needed hospital care to:

1. Veterans for service-connected disabilities
2. Service-connected disabled veterans rated at 50% or more
3. Other service-connected disabled veterans
4. POWs
5. Veterans exposed to Agent Orange or radiation
6. Veterans of World War I and earlier conflicts
7. Veterans with no service-connected disabilities who are "unable to defray the costs of needed hospital care"—meaning those who are either VA improved-pension recipients or Medicaid eligible or who have incomes not exceeding $15,000 for a

veteran with no dependents and $18,000 for a veteran with one dependent plus $1,000 for each additional dependent, called the "Category A" income threshold.

In connection with the foregoing, the Joint Explanatory Statement states that:

> The conferees intend that care be furnished to service-connected disabled veterans, low-income veterans, and, to the extent resources are available, other eligible veterans.
>
> The conferees intend that for categories 1-8, the VA's sole obligation is (1) if a veteran is in immediate need of hospitalization, to furnish an appropriate bed at the VA facility where the veteran applies or, if none is available there, to furnish a contract bed if authorized in section 603 or arrange to admit the veteran to the next closest VAMC, or DOD facility with which the VA has a sharing agreement, with an available bed, or (2) if the veteran needs non-immediate hospitalization, (A) schedule the veteran for admission there if the schedule there permits, or (B) refer the veteran for scheduling and admission to the next closest VAMC, or DOD facility with which the VA has a sharing agreement, with an available bed and then facilitate the veteran's admission there.
>
> The conferees intend that, if there are two or more veterans applying for the same bed at a particular facility and one is seeking care for a service-connected disability or has a 50-percent-or-more service-connected disability, that veteran should receive the bed.
>
> The conferees note that the legislation makes no change in the beneficiary travel program.

B. VA may, in VA facilities and in non-VA facilities as authorized in section 603, furnish needed hospital care to the extent that facilities and resources are available, to:

> 1. Non-service-connected veterans with incomes above the Category A income threshold.
>
> 2. Non-service-connected veterans with incomes above $20,000 for a veteran with no dependents and $25,000 for a veteran with 1 dependent plus $1,000 for each additional dependent—called the "Category B" income threshold—on the basis of an agreement to make a payment (similar to the Medicare deductible) in connection with such care.

In connection with the foregoing, the Joint Explanatory Statement states that the conferees intend that those veterans making payments in connection with their care would have lowest priority for inpatient, outpatient, and nursing home care.

C. In the case of a veteran whose income in the previous year is above the Category A income threshold or the Category B income threshold, the Administrator would be authorized to make an exception to place the veteran in a higher-priority category, as appropriate, on the basis of a recent, sharp drop in income to a level substantially below the Category A or B threshold.

Outpatient eligibility

Essentially no change in current law; eligibility based on hospital-care eligibility.

Nursing home and domiciliary care eligibility

No change in current law.

Priorities for care

No change in current law except to add veterans receiving VA improved pension benefits (under section 512) as a new last priority category (in section 612(i)) for outpatient care.

Contract care

No change from eligibility in current law.

Income thresholds

Category A and B as set forth above with the dollar amounts increased, beginning January 1, 1987, by the preceding year's Social Security/VA pension CPI.

Payments by veterans

A. *Hospital care:* Payment of the Medicare deductible for the first 90 days of care, and half of the deductible for each succeeding additional 90 days of care, within a 365-day period.

B. *Outpatient care:* Per-visit payment of 20% of the VA average daily rate, not to exceed the Medicare deductible for any 90-day period.

C. *Nursing home care:* Payment of the Medicare deductible for each 90 days of care.

D. *Combinations of modes of care:* Payments made for either mode of inpatient care (hospital or nursing home) would be credited toward care in the other mode. Also, a veteran would not be required to pay an amount greater than the inpatient Medicare deductible in connection with any combination of outpatient and hospital or nursing home care furnished during any 90-day period.

Compensation COLA

[Compensation COLA provisions deleted in final version.]

Health-insurance recovery

Provide for VA recovery from health insurers for non-service-connected VA care furnished to covered veterans generally to the same extent as recovery by non-federal providers would be permitted under the health insurance plan in question.

CHANGES IN EXISTING LAW MADE BY TITLE XIX OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

Changes in existing law made by Title XIX of the Consolidated Omnibus Budget Reconciliation Act of 1985 are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

* * * * * * *

PART II—GENERAL BENEFITS

* * * * * * *

CHAPTER 15—PENSION FOR NON-SERVICE-CONNECTED DISABILITY OR DEATH OR FOR SERVICE

* * * * * * *

Subchapter II—Veterans' Pensions

* * * * * * *

NON-SERVICE-CONNECTED DISABILITY PENSION

* * * * * * *

§ 525. Temporary protection of health-care eligibility

(a) In the case of a veteran whose entitlement to pension under section 521 of this title is terminated during the program period by reason of income from work or training, the veteran shall retain for a period of three years beginning on the date of such termination all eligibility for care and services under such chapter that the veteran would have had if the veteran's entitlement to pension had not been terminated. Care and services for which such a veteran retains eligibility include, when applicable, drugs and medicines under section 612(h) of this title and special priority with respect to such care and services under [section 612(i)(5)] *clauses (5) and (6) of section 612(i)* of this title.

* * * * * * *

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I—GENERAL

Sec.
601. Definitions.
602. Presumptions relating to psychosis.
603. Contracts for hospital care and medical services in non-Veterans' Administration facilities.

* * * * * * *

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

621. Power to make rules and regulations.
[622. Evidence of inability to defray necessary expenses.]
622. Determination of inability to defray necessary expenses; income thresholds.
623. Furnishing of clothing.
624. Hospital care, medical services, and nursing home care abroad.
625. [REPEALED.]
626. Reimbursement for loss of personal effects by natural disaster.
627. Persons eligible under prior law.
628. Reimbursement of certain medical expenses.
629. Recovery by the United States of the cost of certain care and services.
630. Community residential care.

* * * * * * *

Subchapter I—General

§ 601. Definitions

For the purposes of this chapter—

* * * * * * *

(4) The term "Veterans' Administration facilities" means—

(A) facilities over which the Administrator has direct jurisdiction; *and*

(B) Government facilities for which the Administrator [contracts; and] *contracts.*

[(C) private facilities for which the Administrator contracts when facilities described in clause (A) or (B) of this paragraph are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the care or services required in order to provide (i) hospital care or medical services to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service; (ii) medical services for the treatment of any disability of a veteran described in clause (1)(B) or (2) of the first sentence, or in the third sentence, of section 612(f) of this title or of a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in facilities described in clauses (A) and (B) of this paragraph; (iii) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of

a veteran receiving medical services in a facility described in clause (A) or (B) of this paragraph until such time as the veteran can be safely transferred to any such facility; (iv) hospital care for women veterans; (v) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the forty-eight contiguous States, except that the annually determined hospital patient load and incidence of the provision of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and private facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by the Veterans' Administration within the forty-eight contiguous States, but the authority of the Administrator under this subclause (except with respect to Alaska and Hawaii) shall expire on September 30, 1985, and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the Commonwealth of Puerto Rico and to the Virgin Islands of the restrictions in this subclause with respect to hospital patient loads and incidence of provision of medical services; or (vi) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, the provision of medical services at independent Veterans' Administration outpatient clinics to obviate the need for hospital admission.

In the case of any veteran for whom the Administrator contracts to provide treatment in a private facility pursuant to the provisions of this paragraph, the Administrator shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.]

* * * * * * *

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 610 and 612 of this title, optometric and podiatric services (in the case of a person otherwise receiving care or services under this chapter), preventive health-care services as defined in section 662 of this title, and (except under the conditions described in section [612(f)(1)(A)] *612(f)(1)(A)(i)* of this title), wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Administrator determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

(B) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

(i) of the service-connected disability of a veteran pursuant to section 612(a) of this title, and

(ii) in the discretion of the Administrator, of the nonservice-connected disability of a veteran eligible for treat-

ment under section [612(f)(1)(B)] *612(f)(1)(A)(ii)* of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title). For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title shall be eligible for the same medical services as a veteran.

* * * * * * *

(9) The term "non-Veterans' Administration facilities" means facilities other than Veterans' Administration facilities.

* * * * * * *

§ 603. Contracts for hospital care and medical services in non-Veterans' Administration facilities

(a) When Veterans' Administration facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Administrator, as authorized in section 610 or 612 of this title, may contract with non-Veterans' Administration facilities in order to furnish—

(1) hospital care or medical services to a veteran for the treatment of—

(A) a service-connected disability; or

(B) a disability for which a veteran was discharged or released from the active military, naval, or air service;

(2) medical services for the treatment of any disability of—

(A) a veteran described in section 612(a)(1)(B) of this title;

(B) a veteran described in section 612(f)(1)(A)(ii) of this title; or

(C) a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in Veterans' Administration facilities;

(3) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a Veterans' Administration facility until such time following the furnishing of care

in the non-Veterans' Administration facility as the veteran can be safely transferred to a Veterans' Administration facility;

(4) hospital care for women veterans;

(5) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the contiguous States, except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and non-Veterans' Administration facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the furnishing of medical services for veterans hospitalized or treated by the Veterans' Administration within the 48 contiguous States, but the authority of the Administrator under this paragraph with respect to the Commonwealth of Puerto Rico shall expire on September 30, 1988, and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the Commonwealth of Puerto Rico of the restrictions in this paragraph with respect to hospital patient loads and the incidence of the furnishing of medical services;

(6) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent Veterans' Administration out-patient clinics to obviate the need for hospital admission; or

(7) outpatient dental services and treatment, and related dental appliances, for a veteran described in section 612(b)(1)(G) of this title.

(b) In the case of any veteran for whom the Administrator contracts to furnish care or services in a non-Veterans' Administration facility pursuant to a provision of subsection (a) of this section, the Administrator shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.

Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

§ 610. Eligibility for hospital, nursing home, and domiciliary care

[(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to—

[(1)(A) any veteran for a service-connected disability; or

[(B) any veteran for a non-service-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care;

[(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

[(3) a person (A) who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation, or (B) who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is

provided for in the judgment or settlement described in such section;

[(4) a veteran who is a former prisoner of war;

[(5) a veteran who meets the conditions of subsection (e) of this section; and

[(6) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older.]

(a)(1) The Administrator shall furnish hospital care, and may furnish nursing home care, which the Administrator determines is needed—

(A) to any veteran for a service-connected disability;

(B) to a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty, for any disability;

(C) to a veteran who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section, for any disability;

(D) to a veteran who has a service-connected disability rated at 50 percent or more, for any disability;

(E) to any other veteran who has a service-connected disability, for any disability;

(F) to a veteran who is a former prisoner of war, for any disability;

(G) to a veteran exposed to a toxic substance or radiation, as provided in subsection (e) of this section;

(H) to a veteran of the Spanish-American War, the Mexican border period, or World War I, for any disability; and

(I) to a veteran for a non-service-connected disability, if the veteran is unable to defray the expenses of necessary care as determined under section 622(a)(1) of this title.

(2)(A) To the extent that resources and facilities are available, the Administrator may furnish hospital care and nursing home care which the Administrator determines is needed to a veteran for a non-service-connected disability if the veteran has an income level described in section 622(a)(2) of this title.

(B) In the case of a veteran who is not described in paragraph (1) of this subsection or in subparagraph (A) of this paragraph, the Administrator may furnish hospital care and nursing home care which the Administrator determines is needed to the veteran for a non-service-connected disability—

(i) to the extent that resources and facilities are otherwise available; and

(ii) subject to the provisions of subsection (f) of this section.

(3) In addition to furnishing hospital care and nursing home care described in paragraphs (1) and (2) of this subsection through Veterans' Administration facilities, the Administrator may furnish such hospital care in accordance with section 603 of this title and may furnish such nursing home care as authorized under section 620 of this title.

* * * * * * *

(e)(1)(A) Subject to paragraphs (2) and (3) of this subsection, a veteran—

(i) who served on active duty in the Republic of Vietnam during the Vietnam era, and

(ii) who the Administrator finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used in connection with military purposes during such era,

[may be furnished hospital care or nursing home care under subsection (a)(5)] *is eligible for hospital care and nursing home care under subsection (a)(1)(G)* of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(B) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Administrator finds was exposed while serving on active duty to ionizing radiation from the detonation of a nuclear device in connection with such veteran's participation in the test of such a device or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning on September 11, 1945, and ending on July 1, 1946, [may be furnished hospital care or nursing home care under subsection (a)(5)] *is eligible for hospital care and nursing home care under subsection (a)(1)(G)* of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(2) Hospital and nursing home care may not be provided under subsection [(a)(5)] *(a)(1)(G)* of this section with respect to a disability that is found, in accordance with guidelines issued by the Chief Medical Director, to have resulted from a cause other than an exposure described in subparagraph (A) or (B) of paragraph (1) of this subsection.

(3) Hospital and nursing home care and medical services may not be provided under or by virtue of subsection [(a)(5)] *(a)(1)(G)* of this section after the end of the one-year period beginning on the date the Administrator submits to the appropriate committees of Congress the first report required by section 307(b)(2) of the Veterans Health Programs Extension and Improvement Act of 1979 (Public Law 96-151; 93 Stat. 1098).

(f)(1) The Administrator may not furnish hospital care or nursing home care under this section to a veteran who is eligible for such care by reason of subsection (a)(2)(B) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) of this subsection.

(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to the lesser of—

(A) the cost of furnishing such care, as determined by the Administrator; and

(B) the amount determined under paragraph (3) of this subsection.

(3)(A) In the case of hospital care furnished during any 365-day period, the amount referred to in paragraph (2)(B) of this subsection is—

(i) the amount of the inpatient Medicare deductible, plus

(ii) one-half of such amount for each 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period.

(B) In the case of nursing home care furnished during any 365-day period, the amount referred to in paragraph (2)(B) of this subsection is the amount of the inpatient Medicare deductible for each 90 days of such care (or fraction thereof) during such 365-day period.

(C)(i) Except as provided in clause (ii) of this subparagraph, in the case of a veteran who is admitted for nursing home care under this section after being furnished, during the preceding 365-day period, hospital care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of hospital care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such nursing home care until—

(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

(II) the end of the 365-day period applicable to the hospital care for which payment was made,

whichever occurs first.

(ii) In the case of a veteran who is admitted for nursing home care under this section after being furnished, during any 365-day period, hospital care for which the veteran has paid an amount under subparagraph (A)(ii) of this paragraph and who has not been furnished 90 days of hospital care in connection with such payment, the amount of the liability of the veteran under paragraph (2) of this subsection with respect to the number of days of such nursing home care which, when added to the number of days of such hospital care, is 90 or less, is the difference between the inpatient Medicare deductible and the amount paid under such subparagraph until—

(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

(II) the end of the 365-day period applicable to the hospital care for which payment was made,

whichever occurs first.

(D) In the case of a veteran who is admitted for hospital care under this section after having been furnished, during the preceding 365-day period, nursing home care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of nursing home care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such hospital care until—

(i) the veteran has been furnished, beginning with the first day of such nursing home care furnished in connection with such payment, a total of 90 days of nursing home care and hospital care; or

(ii) the end of the 365-day period applicable to the nursing home care for which payment was made,

whichever occurs first.

(E) A veteran may not be required to make a payment under this subsection for hospital care or nursing home care furnished under this section during any 90-day period in which the veteran is furnished medical services under section 612(f) of this title to the extent that such payment would cause the total amount paid by the veteran under this subsection for hospital care and nursing home care furnished during that period and under section 612(f)(4) of this title for medical services furnished during that period to exceed the amount of the inpatient Medicare deductible in effect on the first day of such period.

(4) Amounts collected or received on behalf of the United States under this subsection shall be deposited in the Treasury as miscellaneous receipts.

(5) For the purposes of this subsection, the term "inpatient Medicare deductible" means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) on the first day of the 365-day period applicable under paragraph (3) of this subsection.

(g) Nothing in this section requires the Administrator to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government.

* * * * * * *

§ 612. Eligibility for medical treatment

(a) [Except as provided in subsection (b) of this section, the Administrator, within the limits of Veterans' Administration facilities, may furnish such medical services as the Administrator finds to be reasonably necessary to any veteran for a service-connected disability.] *(1) Except as provided in subsection (b) of this section, the Administrator may furnish such medical services as the Administrator determines are needed—*

(A) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service); and

(B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more.

(2) [The Administrator may also furnish to any such veteran] *As part of medical services furnished to a veteran under paragraph (1) of this subsection, the Administrator may furnish to the veteran* such home health services as the Administrator finds to be necessary or appropriate for the effective and economical treatment of such disability (including only such improvements and structural alterations the cost of which does not exceed $2,500 (or reimbursement up to such amount) as are necessary to assure the continu-

ation of treatment for such disability or to provide access to the home or to essential lavatory and sanitary facilities). [In the case of any veteran discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, such services may be so furnished for that disability, whether or not service-connected for the purposes of this chapter.]

(3) In addition to furnishing medical services under this subsection through Veterans' Administration facilities, the Administrator may furnish such services in accordance with section 603 of this title.

(b)(1) * * *

* * * * * * *

(3) The total amount which the Administrator may expend for furnishings, during any twelve-month period, outpatient dental services, treatment, or related dental appliances to a veteran under this section through private facilities for which the Administrator has contracted under clause [(i), (ii), or (v) of section 601(4)(C)] *(1), (2), or (5) of section 603(a)* of this title may not exceed $500 unless the Administrator determines, prior to the furnishing of such services, treatment, or appliances and based on an examination of the veteran by a dentist employed by the Veterans' Administration (or, in an area where no such dentist is available, by a dentist conducting such examination under a contract or fee arrangement), that the furnishing of such services, treatment, or appliances at such cost is reasonably necessary.

(4) In any year in which the President's Budget for the fiscal year beginning October 1 of such year includes an amount for expenditures for contract dental care under the provisions of subsections (a) and (f) of this section and section [601(4)(C)] *603* of this title during such fiscal year in excess of the level of expenditures made for such purpose during fiscal year 1978, the Administrator shall, not later than February 15 of such year, submit a report to the appropriate committees of the Congress justifying the requested level of expenditures for contract dental care and explaining why the application of the criteria prescribed in section [601(4)(C)] *603* of this title for contracting with private facilities and in the second sentence of section 610(c) of this title for furnishing incidental dental care to hospitalized veterans will not preclude the need for expenditures for contract dental care in excess of the fiscal year 1978 level of expenditures for such purpose. In any case in which the amount included in the President's Budget for any fiscal year for expenditures for contract dental care under such provisions is not in excess of the level of expenditures made for such purpose during fiscal year 1978 and the Administrator determines after the date of submission of such budget and before the end of such fiscal year that the level of expenditures for such contract dental care during such fiscal year will exceed the fiscal year 1978 level of expenditures, the Administrator shall submit a report to the appropriate committees of the Congress containing both a justification (with respect to the projected level of expenditures for such fiscal year) and an explanation as required in the preceding sentence in the case of a report submitted pursuant to such sentence. Any report submitted pursuant to this paragraph shall in-

clude a comment by the Administrator on the effect of the application of the criteria prescribed in the second sentence of section 610(c) of this title for furnishing incidental dental care to hospitalized veterans.

* * * * * * *

(f) [The Administrator, within the limits of Veterans' Administration facilities, may] *(1) Except as provided in paragraph (4) of this subsection, the Administrator may* furnish medical services for any disability on an outpatient or ambulatory basis—

[(1)] *(A)* to any veteran eligible for hospital care under section 610 of this title [(A)] *(i)* where such services are reasonably necessary in preparation for, or (to the extent that facilities are available) to obviate the need of, hospital admission, or [(B)] *(ii)* where such a veteran has been furnished hospital care and such medical services are reasonably necessary to complete treatment incident to such hospital care (for a period not in excess of twelve months after discharge from in-hospital treatment, except where the Administrator finds that a longer period is required by virtue of the disability being treated); *and*

[(2) to any veteran who has a service-connected disability rated at 50 percent or more; and]

[(3)] *(B)* to any veteran who is a former prisoner of war.

(2) [The Administrator may also furnish to any such veteran] *As part of medical services furnished to a veteran under paragraph (1) of this subsection, the Administrator may furnish to the veteran* such home health services as the Administrator determines to be necessary or appropriate for the effective and economical treatment of a disability of a veteran (including only such improvements and structural alterations the cost of which does not exceed $600 (or reimbursement up to such amount) as are necessary to assure the continuation of treatment or provide access to the home or to essential lavatory and sanitary facilities). [The Administrator may also furnish outpatient dental services and treatment, and related appliances, to any veteran described in clause (G) of subsection (b)(1) of this section.]

(3) In addition to furnishing medical services under this subsection through Veterans' Administration facilities, the Administrator may furnish such services in accordance with section 603 of this title.

(4)(A) The Administrator may not furnish medical services under this subsection (including home health services under paragraph (2) of this subsection) to a veteran who is eligible for hospital care under this chapter by reason of section 610(a)(2)(B) of this title unless the veteran agrees to pay to the United States the amount determined under subparagraph (B) of this paragraph.

(B) A veteran who is furnished medical services under this subsection and who is required under subparagraph (A) of this paragraph to agree to pay an amount to the United States in order to be furnished such services shall be liable to the United States, in the case of each visit in which such services are furnished to the veteran, for an amount equal to 20 percent of the estimated average cost (during the calendar year in which the services are furnished) of an outpa-

tient visit in a Veterans' Administration facility. Such estimated average cost shall be determined by the Administrator.

(C) A veteran may not be required to make a payment under this paragraph for services furnished under this subsection during any 90-day period to the extent that such payment would cause the total amount paid by the veteran under this paragraph for medical services furnished during that period and under section 610(f) of this title for hospital and nursing home care furnished during that period to exceed the amount of the inpatient Medicare deductible in effect on the first day of such 90-day period.

(D) This subsection does not apply with respect to home health services under this subsection to the extent that such services are for improvements and structural alterations.

(E) For the purposes of this paragraph, the term "inpatient Medicare deductible" means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)).

(F) Amounts collected or received by the Veterans' Administration under this paragraph shall be deposited in the Treasury as miscellaneous receipts.

[(g) In the case of any veteran who is a veteran of the Mexican border period or of World War I or who is in receipt of increased pension or additional compensation or allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance, the Administrator, within the limits of Veterans' Administration facilities, may furnish the veteran such medical services as the Administrator finds to be reasonably necessary. The Administrator may also furnish to any such veteran home health services under the terms and conditions set forth in subsection (f) of this section.]

(g)(1) The Administrator may furnish medical services which the Administrator determines are needed to a veteran—

(A) who is a veteran of the Mexican border period or of World War I; or

(B) who is in receipt of increased pension or additional compensation or allowances based on the need of regular aid and attendance or by reason of being permanantly housebound (or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance).

(2) As part of medical services furnished to a veteran under paragraph (1) of this subsection, the Administrator may furnish to the veteran home health services under the terms and conditions set forth in subsection (f) of this section.

(3) In addition to furnishing medical services under this subsection through Veterans' Administration facilities, the Administrator may furnish such services in accordance with section 603 of this title.

* * * * * * *

(i) The Administrator shall prescribe regulations to ensure that special priority in furnishing medical services under this section and any other outpatient care with funds appropriated for the medical care of veterans shall be accorded in the following order,

unless compelling medical reasons require that such care be provided more expeditiously:

(1) To any veteran for a service-connected disability.

(2) To any veteran described in subsection (f)(2) of this section.

(3) To any veteran with a disability rated as service-connected (including any veteran being examined to determine the existence or rating of a service-connected disability).

(4) To any veteran (A) who is a former prisoner of war, or (B) who is eligible for care under section 610(a)(5) of this title.

(5) To any veteran being furnished medical services under subsection (g) of this section.

(6) To any veteran who is in receipt of pension under section 521 of this title.

* * * * * * *

§ 612A. Eligibility for readjustment counseling and related mental health services

(a) * * *

* * * * * * *

(b)(1) If, on the basis of the assessment furnished under subsection (a) of this section, a physician or psychologist employed by the Veterans' Administration (or, in areas where no such physician or psychologist is available, a physician or psychologist carrying out such function under a contract or fee arrangement with the Administrator) determines that the provision of mental health services to such veteran is necessary to facilitate the successful readjustment of the veteran to civilian life, such veteran shall, within the limits of Veterans' Administration facilities, be furnished such services on an outpatient basis under the conditions specified in [clause (1)(B)] *paragraph (1)(A)(ii)* of section 612(f) of this title. For the purposes of furnishing such mental health services, the counseling furnished under subsection (a) of this section shall be considered to have been furnished by the Veterans' Administration as a part of hospital care. Any hospital care and other medical services considered necessary on the basis of the assessment furnished under subsection (a) of this section shall be furnished only in accordance with the eligibility criteria otherwise set forth in this chapter (including the eligibility criteria set forth in section 611(b) of this title).

* * * * * * *

(e)(1) In furnishing counseling and related mental health services under subsections (a) and (b) of this section, the Administrator shall have available the same authority to enter into contracts with private facilities that is available to the Administrator (under sections [612(f)(2)] *612(a)(1)(B)* and [601(4)(C)(ii)] *603(a)(2)* of this title) in furnishing medical services to veterans suffering from total service-connected disabilities.

* * * * * * *

§ 620. Transfers for nursing home care; adult day health care

(a) * * *

* * * * * * * *

(f)(1)(A) The Administrator is authorized to furnish adult day health care as provided for in this subsection. For the purpose only of authorizing the furnishing of such care and specifying the terms and conditions under which it may be furnished to veterans needing such care—

(i) references to "nursing home care" in subsection (a) through (d) of this section shall be deemed to be references to "adult day health care", and

(ii) a veteran who is eligible for medical services under section [612(f)(2)] *612(a)(1)(B)* of this title shall be deemed to be a veteran described in subsection (a)(1) of this section.

* * * * * * * *

Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

* * * * * * * *

[§ 622. Evidence of inability to defray necessary expenses

[For the purposes of sections 610(a)(1)(B), 610(b)(2), 624(c), and 632(a)(2) of this title, the fact that an individual is—

[(1) eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

[(2) a veteran with a service-connected disability; or

[(3) in receipt of pension under any law administered by the Veterans' Administration;

[shall be accepted as sufficient evidence of such individual's inability to defray necessary expenses.]

§ 622. Determination of inability to defray necessary expenses; income thresholds

(a)(1) For the purposes of section 610(a)(1)(I) of this title, a veteran shall be considered to be unable to defray the expenses of necessary care if—

(A) the veteran is eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(B) the veteran is in receipt of pension under section 521 of this title; or

(C) the veteran's attributable income is not greater than the Category A threshold.

(2) For the purposes of section 610(a)(2)(A) of this title, a veteran's income level is described in this paragraph if the veteran's attributable income is not greater than the Category B threshold.

(b) For the purposes of this section:

(1) The Category A threshold—

(A) for the calendar year beginning on January 1, 1986, is—

(i) $15,000 in the case of a veteran with no dependents; and

(ii) $18,000 in the case of a veteran with one dependent, plus $1,000 for each additional dependent; and

(B) for a calendar year beginning after December 31, 1986, is the amount in effect for purposes of this paragraph for the preceding calendar year as adjusted under subsection (c) of this subsection.

(2) The Category B threshold—

(A) for the calendar year beginning on January 1, 1986, is—

(i) $20,000 in the case of a veteran with no dependents; and

(ii) $25,000 in the case of a veteran with one dependent, plus $1,000 for each additional dependent; and

(B) for a calendar year beginning after December 31, 1986, is the amount in effect for purposes of this paragraph for the preceding calendar year as adjusted under subsection (c) of this subsection.

(c) Effective on January 1 of each year, the amounts in effect under paragraphs (1) and (2) of subsection (b) of this section shall be increased by the percentage by which the maximum rates of pension were increased under section 3112(a) of this title during the preceding calendar year.

(d)(1) Notwithstanding the attributable income of a veteran, the Administrator may refuse to make a determination described in paragraph (2) of this subsection if the corpus of the estate of the veteran is such that under all the circumstances it is reasonable that some part of the corpus of the estate of the veteran be consumed for the veteran's maintenance.

(2) A determination described in this paragraph is a determination—

(A) that for the purposes of subsection (a)(1)(C) of this section a veteran's attributable income is not greater than the Category A threshold; or

(B) that for the purposes of subsection (a)(2) of this section a veteran's attributable income is not greater than the Category B threshold.

(3) For the purposes of paragraph (1) of this subsection, the corpus of the estate of a veteran shall be determined in the same manner as the manner in which determinations are made of the corpus of the estates of persons under section 522 of this title.

(e)(1) In order to avoid a hardship to a veteran described in paragraph (2) of this subsection, the Administrator may deem the veteran to have an attributable income during the previous year not greater than the Category A threshold or the Category B threshold, as appropriate.

(2)(A) A veteran is described in this paragraph for the purposes of subsection (a)(1) of this section if—

(i) the veteran has an attributable income greater than the Category A threshold; and

(ii) the current projections of such veteran's income for the current year are that the veteran's income for such year will be substantially below such threshold.

(B) A veteran is described in this paragraph for the purposes of subsection (a)(2) of this section if—

(i) the veteran has an attributable income greater than the Category B threshold; and

(ii) the current projections of such veteran's income for the current year are that the veteran's income for such year will be substantially below such threshold.

(f) For purposes of this section:

(1) The term "attributable income" means the income of a veteran for the previous year determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such veteran under section 521 of this title would be reduced if such veteran were eligible for pension under that section.

(2) The term "corpus of the estate of the veteran" includes the corpus of the estates of the veteran's spouse and dependent children, if any.

(3) The term "previous year" means the calendar year preceding the year in which the veteran applies for care or services under section 610(a) or 612(f) of this title.

(g) For the purposes of sections 610(b)(2) and 624(c) of this title, the fact that a veteran is—

(1) eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) a veteran with a service-connected disability; or

(3) in receipt of pension under any law administered by the Veterans' Administration,

shall be accepted as sufficient evidence of such veteran's inability to defray necessary expenses.

* * * * * * *

§ 629. Recovery by the United States of the cost of certain care and services

(a) [In] *(1) Subject to the provisions of this section, in* any case in which a veteran is furnished care [and] *or* services under this chapter for a non-service-connected disability [that was incurred—] *described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Administrator) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.*

(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

[(1)]*(A) that is incurred* incident to the veteran's employment and [the disability] *that* is covered under a workers' compensation law or plan that provides [reimbursement] *for payment* for [or indemnification of] the cost of health care and services provided to the veteran by reason of the [disability,] *disability;*

[(2)] *(B) that is incurred* as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations [insurance, or] *insurance;*

[(3)] *(C) that is incurred* as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such [crime,] *crime; or*

[the United States has the right to recover the reasonable costs of such care and services from the State, or political subdivision of a State, employer, employer's insurance carrier, or automobile accident reparations insurance carrier, as appropriate, to the extent that the veteran, or the provider of care and services to the veteran, would be eligible to receive reimbursement or indemnification for such care and services if the care and services had not been furnished by a department or agency of the United States.]

(D) that is incurred by a veteran—

(i) who does not have a service-connected disability; and

(ii) who is entitled to care (or payment of the expenses of care) under a health-plan contract.

(3) In the case of a health-plan contract that contains a requirement for payment of a deductible or copayment by the veteran—

(A) the veteran's not having paid such deductible or copayment with respect to care or services furnished under this chapter shall not preclude recovery or collection under this section; and

(B) the amount that the United States may collect or recover under this section shall be reduced by the appropriate deductible or copayment amount, or both.

(b) [The amount that may be recovered by the United States under subsection (a) of this section may not exceed the lesser of (1) an amount equal to the reasonable cost of the care and services furnished the veteran under this chapter, as determined by the Administrator, or (2) the maximum amount specified by the law of the State or political subdivision concerned or by any relevant contractual provision to which the veteran was a party or was subject. The Administrator shall prescribe regulations for the determination of the reasonable cost of care and services under clause (1) of the preceding sentence, and any determination of such reasonable value by the Administrator under such clause shall be made in accordance with such regulations. Regulations under the preceding sentence shall be prescribed only after notice and opportunity for public comment.]

[(c)(1) The] *(1) As to the right provided in subsection (a) of this section, the* United States shall [, as to the right provided in subsection (a) of this section,] be subrogated to any right or claim that the veteran [or] (*or* the veteran's personal representative, successor, dependents, or [survivors] *survivors*) may have against a [State or political subdivision of a State, an employer, an employer's insurance carrier, or an automobile accident reparations insurance carrier.] *third party.*

(2)(A) In order to enforce any right or claim to which [it] *the United States* is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran [or] (*or* the veteran's personal representative, successor, dependents, or [survivors] *survivors*) against a [State or political subdivision of a State, an employer, an employer's insurance carrier, or an automobile accident reparations insurance carrier.] *third party.*

[(B) If—

[(i) no such action or proceeding has been commenced within one hundred and eighty days after the first day on which care and services for which recovery is sought were furnished to the veteran by the Veterans' Administration under this chapter, and

[(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute legal proceedings,

[the United States may, sixty days after the mailing of such notice, institute and prosecute legal proceedings against the State, political subdivision, employer, employer's insurance carrier, or automobile accident reparations insurance carrier.]

(B) The United States may institute and prosecute legal proceedings against the third party if—

(i) an action or proceeding described in subparagraph (A) of this paragraph is not begun within 180 days after the first day on which care or services for which recovery is sought are furnished to the veteran by the Administrator under this chapter;

(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute such legal proceedings; and

(iii) a period of 60 days has passed following the mailing of such notice.

(c)(1) The Administrator may compromise, settle, or waive any claim which the United States has under this section.

(2)(A) The Administrator, after consultation with the Comptroller General of the United States, shall prescribe regulations for the purpose of determining the reasonable cost of care or services under subsection (a)(1) of this section. Any determination of such cost shall be made in accordance with such regulations.

(B) Such regulations shall provide that the reasonable cost of care or services sought to be recovered or collected from a third-party liable under a health-plan contract may not exceed the amount that such third party demonstrates to the satisfaction of the Administrator it would pay for the care or services in accordance with the prevailing rates at which the third party makes payments under comparable health-plan contracts with facilities (other than facilities of departments or agencies of the United States) in the same geographic area.

(C) Not later than 45 days after the date on which the Administrator prescribes such regulations (or any amendment to such regulations), the Comptroller General shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives

the Comptroller General's comments on and recommendations regarding such regulations (or amendment).

(d) Any contract or agreement into which the Administrator enters with a person under section 3718 of title 31 for collection services to recover indebtedness owed the United States under this section shall provide, with respect to such services, that such person is subject to sections 3301 and 4132 of this title.

[(d)](e) A veteran eligible for care [and] *or* services under this chapter—

(1) may not be denied such care [and] *or* services by reason of this [section.] *section; and*

(2) may not be required by reason of this section to make any copayment or deductible payment in order to receive such care.

[(e)](f) No law of any State or of any political subdivision of a State, and no provision of any contract or [agreement entered into, renewed, or modified under any State law,] *other agreement,* shall operate to prevent recovery *or collection* by the United States [(1)] under [subsection (a) of] this section [for care and] *or with respect to care or* services furnished under [this chapter to any veteran for a non-service-connected disability, or (2) under] section 611(b) of this [title for care and services furnished under such section to an individual as a humanitarian service in an emergency case.] *title.*

(g) Amounts collected or recovered on behalf of the United States under this section shall be deposited into the Treasury as miscellaneous receipts.

(h)(1) Subject to paragraph (3) of this subsection, the Administrator shall make available medical records of a veteran described in paragraph (2) of this subsection for inspection and review by representatives of the third party concerned for the sole purposes of permitting the third party to verify—

(A) that the care or services for which recovery or collection is sought were furnished to the veteran; and

(B) that the provision of such care or services to the veteran meets criteria generally applicable under the health-plan contract involved.

(2) A veteran described in this paragraph is a veteran who is a beneficiary of a health-plan contract under which recovery or collection is sought under this section from the third party concerned for the cost of the care or services furnished to the veteran.

(3) Records shall be made available under this subsection under such conditions to protect the confidentiality of such records as the Administrator shall prescribe in regulations.

(i) For purposes of this section—

(1)(A) The term "health-plan contract" means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.

(B) Such term does not include—

(i) an insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j);

(ii) a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.);

(iii) a workers' compensation law or plan described in subparagraph (A) of subsection (a)(2) of this section; or

(iv) a program, plan, or policy under a law described in subparagraph (B) or (C) of such subsection.

(2) The term "payment" includes reimbursement and indemnification.

(3) The term "third party" means—

(A) a State or political subdivision of a State;

(B) an employer or an employer's insurance carrier;

(C) an automobile accident reparations insurance carrier; or

(D) a person obligated to provide, or to pay the expenses of, health services under a health-plan contract.

* * * * * * *

Subchapter VII—Preventive Health-Care Services Pilot Program

* * * * * * *

§ 663. Preventive health-care services

(a)(1) In order to carry out the purpose of this subchapter, the Administrator, within the limits of Veterans' Administration facilities and in accordance with regulations which the Administrator shall prescribe, shall, during fiscal years 1984 through 1988, furnish to any veteran described in section [612(f)(2)] *612(a)(1)(B)* of this title otherwise being furnished care or services under this chapter, and to any veteran receiving care or services under this chapter involving a service-connected disability, such preventive health-care services as the Administrator determines are feasible and appropriate. In carrying out the pilot program under this subchapter, the Administrator may furnish such preventive health-care services to any other veteran described in section [612(f)(2)] *612(a)(1)(B)* of this title.

* * * * * * *

CHAPTER 23—BURIAL BENEFITS

* * * * * * *

§ 903. Death in Veterans' Administration facility; plot allowance

(a) When a veteran dies in a Veterans' Administration facility (as defined in section 601(4) of this title) to which the deceased was properly admitted for hospital, nursing home, or domiciliary care under section 610 or 611(a) of this title or in an institution at which the deceased veteran was receiving *hospital care in accordance with section 603 of this title or* nursing home care under section 620 of this title at the expense of the United States at the time of death, the Administrator—

(1) shall pay the actual cost (not to exceed $300) of the burial and funeral or, within such limits, may make contracts for such services without regard to the laws requiring advertise-

ment for proposals for supplies and services for the Veterans' Administration; and

(2) shall, when such a death occurs in a State, transport the body to the place of burial in the same or any other State.

* * * * * * *

VETERANS' ADMINISTRATION HEALTH-CARE AMENDMENTS OF 1985

(PUBLIC LAW 99-166, DECEMBER 3, 1985)

* * * * * * *

TITLE I—HEALTH-CARE PROGRAMS

* * * * * * *

SEC. 102. SPECIAL CONTRACT-CARE AUTHORITY OUTSIDE THE 48 CONTIGUOUS STATES.

(a) * * *

* * * * * * *

(b) PHASE-OUT OF SPECIAL AUTHORITY IN PUERTO RICO.—(1) Effective on October 1, 1988, [such section] *section 603(a)(5)* is amended—

(A) by inserting "(other than the Commonwealth of Puerto Rico)" after "in a State"; and

(B) by striking out "contiguous States" the second place it appears and all that follows through "medical services;" and inserting in lieu thereof "contiguous States and the Commonwealth of Puerto Rico;".

* * * * * * *

(5) For the purpose of this subsection, the term "obligations incurred for Puerto Rico contract care" means the total obligations incurred during a fiscal year for medical services for veterans residing in the Commonwealth of Puerto Rico under the Administrator's authority to contract for hospital care or medical services under [clause (v) of section 601(4)(C)] *section 603(a)(5)* of title 38, United States Code, in the Commonwealth of Puerto Rico.

* * * * * * *

COST ESTIMATES PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

A. ASSUMING APRIL 1, 1986 DATE OF ENACTMENT

FINAL RECONCILIATION PROVISIONS

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990	1991
Function 700 impact—means test:						
Deductible collections:						
Budget authority and outlays	−16	−91	−99	−107	−115	−124
Veterans choosing alternative care:						
Budget authority and outlays	−10	−48	−52	−56	−60	−64
Administrative costs:						
Budget authority and outlays	9	26	23	24	24	25
Report to Congress:						
Budget authority and outlays	1	1	1	1	1	1
Net impact, means test:						
Budget authority	−16	−112	−127	−138	−150	−162
Outlays	−16	−112	−127	−138	−150	−162
Third-party reimbursement:						
Collections:						
Budget authority and outlays	−34	−265	−374	−405	−439	−471
Administrative costs:						
Budget authority and outlays	0	2	3	3	3	3
Net impact, third-party reimbursement:						
Budget authority	−34	−263	−371	−402	−436	−468
Outlays	−34	−263	−371	−402	−436	−468
Net function 700 impact:						
Budget authority	−50	−375	−498	−540	−586	−630
Outlays	−50	−375	−498	−540	−586	−630
Function 570 impact:						
Hospital insurance:						
Budget authority	−([1])	−([1])	−1	−1	−2	−3
Outlays	1	4	5	6	6	7
Supplementary medical insurance:						
Budget authority	2	5	6	7	7	8
Outlays	1	5	6	7	7	8
Net function 570 impact:						
Budget authority	2	5	5	6	5	5
Outlays	2	9	11	13	13	15
Net budgetary impact:						
Budget authority	−48	−370	−493	−534	−581	−625
Outlays	−48	−366	−487	−527	−573	−615

[1] Less than $500,000.

B. ASSUMING JANUARY 1, 1986 DATE OF ENACTMENT

CBO ESTIMATE OF SUBCONFERENCE 30 RECONCILIATION PROVISIONS DISTRIBUTED BY ACCOUNT

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Function 700—medical care account:					
A. Savings from veterans choosing alternative care:					
Budget authority	−18	−44	−48	−52	−57
Outlays	−18	−44	−48	−52	−57
B. Administrative costs—means test:					
Budget authority	17	29	29	31	33
Outlays	17	29	29	31	33
C. Administrative costs—third-party reimbursement:					
Budget authority	1	3	3	4	4
Outlays	1	3	3	4	4
D. Report to Congress:					
Budget authority	1	1	1	1	1
Outlays	1	1	1	1	1
Net impact, medical care account:					
Budget authority	1	−11	−15	−16	−19
Outlays	1	−11	−15	−16	−19
Offsetting receipt accounts:					
A. Copayment receipts:					
Budget authority	−29	−82	−88	−96	−105
Outlays	−29	−82	−88	−96	−105
B. Third-party reimbursement receipts:					
Budget authority	−85	−336	−405	−452	−503
Outlays	−85	−336	−405	−452	−503
Total, offsetting receipts:					
Budget authority	−114	−418	−493	−548	−608
Outlays	−114	−418	−493	−548	−608
Compensation account (savings from baseline):					
Budget authority	−84	−102	−104	−106	−107
Outlays	−76	−102	−104	−106	−107
Medical and prosthetic research account:					
Budget authority	8	0	0	0	0
Outlays	1	2	2	2	1
Net function 700 impact:					
Budget authority	−189	−531	−612	−670	−734
Outlays	−188	−529	−610	−668	−733
Function 570—HI trust fund:					
Budget authority	−([1])	−1	−1	−2	−2
Outlays	2	5	6	6	7
SMI trust fund:					
Budget authority	2	4	5	6	6
Outlays	2	4	5	6	6
Net function 570 impact:					
Budget authority	2	3	4	4	4
Outlays	4	9	11	12	13
Subconference 30 total:					
Budget authority	−187	−528	−608	−666	−730
Outlays	−184	−520	−599	−656	−720

[1] Less than $500,000.

C. ASSUMING OCTOBER 1, 1985 DATE OF ENACTMENT

CBO ESTIMATE OF SUBCONFERENCE 30 RECONCILIATION PROVISIONS DISTRIBUTED BY ACCOUNT

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Function 700—medical care account:					
A. Savings from veterans choosing alternative care:					
Budget authority	−29	−44	−48	−52	−57
Outlays	−29	−44	−48	−52	−57
B. Administrative costs—means test:					
Budget authority	23	29	29	31	33
Outlays	23	29	29	31	33
C. Administrative costs—third-party reimbursement:					
Budget authority	1	3	3	4	4
Outlays	1	3	3	4	4
D. Report to Congress:					
Budget authority	1	1	1	1	1
Outlays	1	1	1	1	1
Net impact, medical care account:					
Budget authority	−4	−11	−15	−16	−19
Outlays	−4	−11	−15	−16	−19
Offsetting receipt accounts:					
A. Copayment receipts:					
Budget authority	−47	−82	−88	−96	−105
Outlays	−47	−82	−88	−96	−105
B. Third-party reimbursement receipts:					
Budget authority	−204	−356	−405	−452	−503
Outlays	−204	−356	−405	−452	−503
Total, offsetting receipts:					
Budget authority	−251	−438	−493	−548	−608
Outlays	−251	−438	−493	−548	−608
Compensation account (savings from baseline):					
Budget authority	−84	−102	−104	−106	−107
Outlays	−76	−102	−104	−106	−107
Medical and prosthetic research account:					
Budget authority	8	0	0	0	0
Outlays	1	2	2	2	1
Net function 700 impact:					
Budget authority	−331	−551	−612	−670	−734
Outlays	−330	−549	−610	−668	−733
Function 570—HI trust fund:					
Budget authority	−([1])	−1	−1	−2	−2
Outlays	3	5	6	6	7
SMI trust fund:					
Budget authority	3	4	5	6	6
Outlays	3	4	5	6	6
Net function 570 impact:					
Budget authority	3	3	4	4	4
Outlays	6	9	11	12	13
Subconference 30 total:					
Budget authority	−328	−548	−608	−666	−730
Outlays	−324	−540	−599	−656	−720

[1] Less than $500,000

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